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ABSTRACT

Investigated were number and location of community residences or halfway houses (of fewer than 61 persons) for the mildly retarded and their programing practices. Form letters and questionnaires uncovered 68 programs meeting internal delimitations of the study. Programs were categorized for analysis purposes into California Programs, New Programs (in operation for 12 months or less), and Old Programs. Analysis of data showed the majority of non-California programs in Texas and Florida. Clients in Old Programs had short lengths of stay (mean of 22 months), used public facilities and contributed to own maintenance in 60% of the cases, and went independently to jobs in over half of the cases. New Programs resembled Old Programs except that over 60% of the New were integrated by sex. Although 51 halfway houses were found outside California, not one for the mildly retarded was found in California. The sample of existing California Programs (Family Homes and Resident Facilities) were characterized by fewer residents, longer stays, lower estimated IQ, little community involvement, and lower level of self-maintenance. Patients were not normalized to the extent of residents in other programs. (KW)

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HALFWAY HOUSES FOR THE MILDLY RETARDED

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by

Gilbert P. Gia

A thesis

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fulfillment of the requirements for the degree of

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Chapter 1

INTRODUCTION

Attitudes toward mental retardation are changing, and as they change, services to the retarded are affected. The Declaration of General and Special Rights of the Mentally Retarded has been widely recognized.[1] The philosophy of normalization asserts the rights of the mentally retarded to live meaningful lives in the community.[2] Evidence of the Federal Government's commitment to mental retardation is ubiquitous.

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[1]U.S., President's Committee on Mental Retardation, MR 69: Toward Progress--The Story of a Decade (Washington, D.C.: Government Printing Office, 1969), p. 30; "Declaration of General and Special Rights of the Mentally Retarded," Deficience Mentale/Mental Retardation, 19 (April, 1969), i, n. citing the International League of Societies for the Mentally Handicapped, Declaration of General and Special Rights of the Mentally Retarded, October 24, 1968, see Appendix A.

[2]B. Nirje, "The Normalization Principle and Its Human Management Implications," Changing Patterns in Residential Services for the Mentally Retarded, eds. R. Kugel and Wolf Wolfensberger (Washington, D.C.: Government Printing Office, 1969), pp. 179-95; see also John W. Kidd, "The Adultated MR," Education and Training of the Mentally Retarded, 5:2 (1970), 71-2; U.S., President's Committee on Mental Retardation, Residential Services for the Mentally Retarded, an Action Policy Proposal (Washington, D.C.: Government Printing Office, 1970), p. v.

Government financing has made possible building construction, academic fellowships, and state hospital research.[3] In April 1969, over 39.9 million dollars in Government monies was approved for the funding of ". . . specially designed public or other nonprofit facilities for the diagnosis, treatment, education, training, or personal care of the mentally retarded, including sheltered workshops which are part of facilities providing comprehensive services."[4] In December, 1968, the Government approved and appropriated over 25.9 million dollars for university related research in mental retardation research centers.[5] The total financial obligation for mental retardation programs in the United States Department of Health, Education, and Welfare for fiscal years 1968-1970 was 14.7 billion dollars, including one billion dollars for training.[6] The Federal Mental Retardation Budget for 1971

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[3]"Help Against Hepatitis," Time, April 5, 1971, p. 75.

[4]U.S., Secretary's Committee on Mental Retardation, Mental Retardation Construction Programs (Washington, D.C.: Government Printing Office, 1969), pp. 37-8.

[5]Construction Programs, p. 4.

[6]U.S., Congress, Senate, Mental Retardation and Other Developmental Disabilities, 1969. Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate First Session on S. 2846 (Washington, D.C.: Government Printing Office, 1969), p. 218.

has been estimated in excess of 350 million dollars.[7]

The creation of state regions and new programs for the amelioration of mental retardation has been a reflection of the importance attached to the problem of mental retardation within the last five years. In Illinois in 1960, no state-aided day care centers existed for the mentally retarded. In 1968, there were forty-nine such centers caring for over 2,800 individuals.[8] California recognized the shortcomings of its system of services to the retarded when the following statement appeared in a state document in 1969: "Experimental and innovative models of community residential care should be encouraged through expansion of present programs for placement from state hospitals into family homes, hostels, cooperative living projects, nurseries, and schools."[9] As of 1971, ten operational Regional Centers were engaged in expediting services to the retarded in California, and special

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[7]U.S., The President's Committee on Mental Retardation, MR 70: the Decisive Decade (Washington, D.C.: Government Printing Office, 1971), p. 19.

[8]State of Illinois, Department of Mental Health, Mental Health the Responsibility of the Community (Springfield, State of Illinois, 1968), p. 13.

[9]State of California, Department of Mental Hygiene, Task Force for Review of Mental Retardation Services, An Action Program for the Mentally Retarded in California, Phase I, A Program for the Department of Mental Hygiene (Sacramento, State of California, June 23, 1969), p. 20.

services to the retarded were assigned to the Department of Mental Hygiene. One responsibility of the Department, as noted in the 1971-1972 State Budget, was

> to provide mental health services including diagnosis, care and treatment, and rehabilitation of mentally ill and mentally retarded persons for whom no other treatment resources are available or suitable.[10]

The National Association for Retarded Children has member groups in every state, and lobbies in Congress. Television networks and sponsors have widened public exposure to mental retardation by televising programs which feature characters as retarded persons.

In California during the last three years the number of retarded persons in State institutions had diminished. From June 30, 1968 to June 30, 1970, 1,872 mentally retarded patients were released from nine hospitals with retarded patients: Agnews, Camarillo, DeWitt, Napa, Patton, Fairview, Pacific, Porterville, and Sonoma State hospitals. The number of releases represented a 14.6 percent reduction in the total population of retarded persons in these hospitals. The estimated percentage change of residents, for fiscal 1971 and 1972, was a

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[10]State of California, California Legislature, Budget Supplement for Human Relations 1971-1972, Vol. III in Budget of the State of California 1971-1972, Submitted by Ronald Reagan, Governor, to the California Legislature 1971 Regular Session (Sacramento: State of California, 1970), p. 308.

negative 11 percent.[11] Patients on leave from the hospitals, by type of leave, numbered 1 percent of the total hospital population, according to a 1969 report. The numbers on Work Placement, Home Leave, and Family Care Leave were divided about equally.[12] Smaller state mental hospital enrollment, in California between 1968 and 1970 reflected a national trend during the same period.[13]

The California Legislature in 1968 directed a study be made of the use and availability of programs for the mentally retarded. The Lanterman Mental Retardation Services Act of 1969 was a result of that study. The act, projected for implementation on July 1, 1971, required a reorganization of California services to the retarded.[14] The undertaking to bring about this reorganization has been termed probably ". . . the first time that an attempt has been made to marshall the resources of State Government,

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[11]State of California, California Legislature, Budget Supplement, p. 308.

[12]State of California, Assembly Office of Research, California Legislature, A Proposal to Reorganize California's Fragmented System of Service for the Mentally Retarded (Sacramento: State of California, March, 1969), p. F-3.

[13]U.S., Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, Mental Health Statistics: Current Facility Report (Arlington, Virginia: n.p., 1969), p. 2.

[14]State of California, Human Relations Agency, Lanterman Mental Retardation Services Act (Sacramento: State of California, 1971), p. i.

'in totum,' on such a broad scale to establish a more efficient and coordinated delivery system of State service."[15]

Services to the retarded have changed slowly, but they have changed for the better. Federal Government allocations have supported innovative groups for the coordination of planning and the exchange of mental retardation data on a national basis.[16] The Government has also funded studies, such as the Dixon State School Project, where an effort was undertaken to examine the problems involved in returning institutionalized patients to the community.[17] At the state level this year, a United States District Court Judge ordered a state hospital to establish appropriate treatment programs for 4,800 patients previously under custodial maintenance.[18] Concomitantly, hospitals have voluntarily developed

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[15]State of California, Human Relations Agency, Mental Retardation Program, Summary Report on Coordinating Committee to Implement AB 225 (September, 1969 to July, 1970) (Sacramento: State of California, 1970), p. 2.

[16]"Data Banks in Mental Retardation," American Journal of Mental Deficiency, 74 (November, 1969), 441-7; U.S., The President's Committee on Mental Retardation, MR: 70, p. 1.

[17]State of Illinois, Interdepartmental Committee on Mental Retardation, Guidelines for Establishing Programs and Services for the Mentally Retarded in Proprietary Homes (Springfield: State of Illinois, June, 1967), p. iii.

[18]"New Right to Treatment," Time, April 5, 1971, pp. 52-3.

personnel upgrading programs, encouraged the study of retardates in the community, and provided recreational and training services to community retardates.[19] In California, "about $160 million from the California General Fund and an additional $20 million or more from Federal and county funds" were identified as annual expenditures for services to the retarded.[20] National directories have listed a variety of locally available services for the retarded, including sheltered workshops, private schools, community centers, group living homes, and geriatric care.[21]

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[19]Doleen Johnson and Zilpha C. Ferryman, "Inservice Training Program for Non-Professional Personnel in a Mental Retardation Center," Mental Retardation, 7:5 (1969), 10-3; Robert B. Edgerton, The Cloak of Competence: Stigma in the Lives of the Mentally Retarded (Berkeley: The University of California Press, 1967), p. ii; Edward W. Cole, "Three Summers; Experiments in Temporary Residential Care of Retardates," Training School Bulletin, 67 (August, 1970).

[20]State of California, Human Relations Agency, Summary Report, p. 2.

[21]Services and Facilities for Exceptional Children, A Listing of Directories (Arlington, Virginia: Council for Exceptional Children, September, 1969), n., Educational Reproduction Service, ED 036 022; The Directory of Residential Facilities for the Mentally Retarded (n.p.: American Association on Mental Deficiency, 1965); 1968 Directory of Rehabilitation Facilities, Listing of Facilities in the United States and Canada (Washington, D.C.: Association of Rehabilitation Centers, 1968); U.S., Department of Health, Education, and Welfare, Directory of State and Local Resources for the Mentally Retarded (Washington, D.C.: Government Printing Office, 1969), n., Educational Reproduction Service, ED 038 784; letter to the investigator, March 23, 1971, U.S., Department

Community residences for the retarded were mentioned as early as 1961, and advocated nationally as beneficial training approaches in 1962.[22] References to these residences have increased significantly in the professional literature during the last six years. A Canadian journal cited over twenty-five facilities in operation in Canada and many in planning stages.[23] In England, the operation of over 250 hostels is funded by the British Government.[24]

> As yet the hostel service is in its infancy, and many people have yet to be convinced that there is a need for it. However, there are now over 250 such hostels and the number is growing every month, proof enough that hostels are here to stay, and that they are indeed an integral part of the community health service.[25]

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of Health, Education, and Welfare, Office of Education, Special Education Information Center, an unpublished listing of institutions and programs for the education of exceptional children in California.

[22]Henry Wechsler, "Transitional Residences for Former Mental Patients," Mental Hygiene, 45:1 (1961), 69; W. I. Gardner and H. W. Nisonger, A Manual on Terminology and Classification in Mental Retardation (monograph supplement to the American Journal of Mental Deficiency) (3d ed.; n.p.: American Association on Mental Deficiency, 1962), pp. 99-100.

[23]"Provincial Development in Community Residences," Deficience Mentale/Mental Retardation, 19 (April, 1969), 7-10.

[24]P. Clark, "Residential Hostels for the Mentally Subnormal," Teaching and Training, 7:2 (1969), 53.

[25]Clark, p. 53.

Regulations designed specifically for the operation of halfway houses are in effect in New York, although these facilities serve other disabilities in addition to mental retardation.[26] Texas and Florida fund the operation of halfway houses for the retarded.[27] Massachusetts has encouraged, but not funded, the development of halfway houses to provide a smooth transition between institutional life and community living.[28]

Commonly, when retarded persons are released from state institutions, they do not demonstrate the adaptive behavior necessary for independent living, nor are they afforded the supportive services necessary in making the adjustment between life styles.[29] Retardates already living in communities should be expected to eventually leave their living circumstances to find others.

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[26]State of New York, Department of Mental Hygiene, Division of Local Services, Regulations for the Operation of Halfway Houses (n.p.: n.p., 1968).

[27]James L. Jackson, "Extended Rehabilitation Services of the Mentally and Physically Handicapped," Rehabilitation Literature, 32:2 (1971), 43-4; based on a letter to the investigator from Dolores Norley, President, Florida Association for Retarded Children, March 12, 1971.

[28]Commonwealth of Massachusetts, Mental Health Department, Public Information Office, News Release, "Halfway Houses" (3 p. memo.), October 24, 1969, cited by Mental Retardation Abstracts, 7:2 (1970), Abstract Number 1431.

[29]Issac N. Wolfson, "Adjustment of Institutionalized Mildly Retarded Patients Twenty Years After Return to the Community," Mental Retardation, 8:4 (1970), 20-9.

Moves have resulted from the death or infirmity of parents, the incompatibility between persons, or emergent desires for independence.[30] Most retardates experience a natural desire to abandon their dependence on parents.[31] Residences for semi-independent living have been suggested as aids in making greater independence possible within the structure of small groups.[32] Community residences guide the retarded and teach them to live wisely and well in the community.[33] Retardates might stay a month or a lifetime, depending upon their own potential for independent living and the skill of residential directors to actualize their potential for independence.[34] The term "community

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[30]Jerome Nitzberg, "Adult Home Program," Journal of Special Education for the Mentally Retarded, 6:2 (Winter, 1970), 92-5.

[31]U.S., Department of Health, Education, and Welfare, Office of the Secretary, Secretary's Committee on Mental Retardation, The Problem of Mental Retardation (Washington, D.C.: Government Printing Office, 1969), pp. 10-2.

[32]Thomas-Robert Ames, "Program Profiles: A Program for Transition to Independence," Mental Retardation, 8:2 (1970); Michael M. Galazan (project administer), A Structured Community Approach to Complete Services for the Retarded, SRS RD-1331-G (n.p.: Jewish Vocational Service, 1970), p. 18.

[33]Edward N. Dettenheim, "The Monetary System," Mental Retardation, 7:1 (1969), 54-64.

[34]L. Dunn, "Small, Special-Purpose Residential Facilities for the Retarded," Changing Patterns in Residential Services for the Mentally Retarded, eds. R. Kugel and Wolf Wolfensberger (Washington, D.C.: The President's Committee on Mental Retardation, 1969), pp. 211-26.

residence," or halfway house for the retarded, does not imply a "cure" in the sense of its connection with the mentally ill or the public offender; it does imply a considered plan to educate for community living.

Although the number of community residences for the retarded does not appear to be large at present, one authority has suggested that the number will grow as this habilitative measure gains popular recognition.[35] In the District of Columbia, existing services could not meet the need for halfway house programs for the retarded.[36] The President's Committee on Mental Retardation has found the need for information on community living to be of sufficient importance to warrant an overview of the ways in which eight states supply a variety of different community oriented services.[37]

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[35]Wolf Wolfensberger, "Twenty Predictions About Future Residential Services in Mental Retardation," Mental Retardation, 7:6 (1969), 51.

[36]District of Columbia, Department of Public Health, Comprehensive Mental Retardation Plan: Final Report of the Mental Retardation Committee (Washington, D.C.: District of Columbia, 1970), p. 30, n., EDRS, ED 031 842.

[37]Letter to the investigator from Marianna Paige, Consultant, President's Committee on Mental Retardation, January 28, 1971.

STATEMENT OF THE PROBLEM

Literature about community residences for the mildly retarded was found to be limited and incapable of affording program developers with a perspective of national programs. Administrators who wish to compile data for planning and programming must communicate individually with known residential community programs. However, the location of community residences has been difficult because national directories have not classified residences on the basis of their training philosophies. Identification of community residences by title is usually not possible, since program names rarely correspond to program purposes.

The lack of information on programs and programming is an obstacle to efficient planning, for planning without information is an arbitrary policy. Administrators utilize resources of ideas, knowledge, personnel, and materials to accomplish goals. Should one or more of their resources be lacking, programming will likely be less effective. Administrators should have an awareness of existing programs and the option to draw comparisons between various types of programs. Presently, program developers have been frustrated in attempts to locate data representative of national programs, because representative data has not been compiled on habilitative community residences for the retarded.

RELEVANT ISSUES

The investigator reasoned that a compilation of data on existing community residences would assist in the programming of future residences, support administrative decisions, facilitate a flow of information exchange, and provide a basis for program comparisons. The study attempted to determine how many community residences were in operation, where they were located, and how programming practices were distributed.

HYPOTHESIS

The investigator hypothesized that at least one hundred community residences for the retarded could be located and therefore a cross-sectional analysis of programs was feasible.

BASIC ASSUMPTIONS

The investigator assumed that an assessment of one hundred programs would provide a sufficient number from which to infer characteristics of the population of community residences, and that correlations could be used to examine relationships between selected characteristics on the test instrument. The assumptions were made that (a) in the course of the study, the term "halfway house" could be used to convey the concept of a community

residence for the mildly retarded; (b) a request for addresses of halfway house programs would result in the referral of programs involving mildly retarded persons; and (c) a questionnaire would identify programs in which clients utilized community facilities and took part in their own personal maintenance.

DELIMITATIONS

This study was characterized by external and internal delimitations. Aspects of the problem not directly controllable by the investigator were termed the external delimitations. The size of the sample depended on (a) the number of existing community residences and official awareness of them; (b) official reaction to the term "halfway house"; (c) official interest in community residences; and (d) the number of questionnaires returned in the study. Because the instrument was a mailed questionnaire, quantity of data was limited. Financial limitations did not allow the investigator to pursue all areas which might have been productive in a larger sampling of programs. Finally, the review of the literature was limited to the immediate resources of the Fresno State College Library and the Special Education Instructional Materials Center of Fresno State College.

The conditions over which the investigator was able to exert greater influence and selection were the internal

delimitations. Programs of two types were sought: California-based programs, and programs located elsewhere. California-based programs were those which served ambulatory, adult retarded. Other programs were those said to be engaged in the habilitation of the mildly retarded in halfway houses.

An evaluation was conducted on those questionnaires which indicated between one and sixty-one residents and a ratio between mentally ill and mentally retarded of less than three to one. All California programs returning completed questionnaires were analyzed.

DEFINITION OF TERMS

(a) Adaptive behavior. Adaptive behavior refers to how effectively persons are able to cope with the natural and social demands of the environment. The mainstream of society requires persons to maintain themselves independently and meet the culturally-imposed demands of personal and social responsibility.[38]

(b) Halfway house. A halfway house is a community residence of fewer than sixty-one persons.

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[38]Rick Heber, "Adaptive Behavior," A Manual on Terminology and Classification in Mental Retardation, eds. W. I. Gardner and H. W. Nisonger (monograph supp. to the American Journal of Mental Deficiency) (2d ed.; n.p.: American Association on Mental Deficiency, 1961), p. 61.

(c) Hostel. A hostel is an abode created

> to provide a comfortable and happy home, with the accent as much as possible on providing a normal family life for the residents, who because of circumstances beyond their control need to reside there;
> to train and rehabilitate the residents, so that he/she will be accepted by the community;
> to find suitable employment for those residents who are able to earn their own living, and
> where and when possible to return the resident to the community when he/she is adjudged to be able to manage his/her own affairs and to be a useful and accepted member of the community.[39]

(d) Letter of inquiry. The letter of inquiry is a letter mailed to public and private officials requesting addresses of halfway houses involved in the habilitation of the mildly retarded. (Appendix B.)

(e) Mild retardation. The term "mild retardation" in this study refers to an impairment of adaptive behavior to the extent that (a) during the teenage years a person can learn academic skills up to approximately sixth grade level and can be guided toward social conformity; and (b) after the teenage years can usually achieve social and vocational skills adequate for minimum self-support, but may need guidance and assistance when under unusual stress from the natural or social environment.[40]

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[39]Clark, pp. 52-3.

[40]U.S., Department of Health, Education, and Welfare, The Problem of Mental Retardation, pp. 8-9.

(f) Normalization principle. The normalization principle implies helping the retarded to obtain patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society.[41]

(g) New Program. New Programs are residences outside California which, at the time of this study, were less than twelve months old.

(h) Old Program. Old Programs are residences outside California which were more than twelve months old at the time of this study.

(i) Questionnaire, or Instrument. These terms are used interchangeably to identify the device used to evaluate programs of community living selected for the sample.

(j) Residence.

> A residential facility for the mentally retarded is any housing facility other than the individual's natural home, which provides supervised living with appropriate services related to the individual's needs.
>
> The primary purpose of residential services is to enable the retarded individual to develop his physical, intellectual and social capabilities to the fullest extent possible, develop emotional maturity, develop whenever possible, skills, habits and attitudes essential for return to community living.[42]

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[41] Kugel and Wolfensberger, p. 181.

[42] U.S., President's Committee on Mental Retardation, Residential Services for the Mentally Retarded, p. 1.

The following terms, when used in reference to California Programs, are associated with the meanings specified in the Licensing Act.[43]

(k) Patient. "A 'patient' shall mean any person who is under observation, care or treatment."[44]

(l) California ambulatory patient. "An ambulatory patient is a person who is capable of demonstrating the physical ability to leave the building without the assistance of any person in case of emergency."[45]

(m) Family Home.

> "Family Home (Mentally Retarded)" is a facility intended for the admission of no more than six (6) mentally retarded patients who are provided with a program of services and protective supervision in a home setting.[46]

(n) California Resident Facility.

> "Resident Facility (Mentally Retarded)" is an institution of seven (7) bed capacity, or more, intended solely for the admission of mentally

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[43]State of California, Department of Mental Hygiene, Division of Local Programs, Bureau of Private Institutions, Private Institution Licensing Act Division 6 Welfare and Institutions Code, and Regulations Related to Private Institutions Title 9, California Administrative Code (Sacramento: State of California, 1969), pp. 1-41.

[44]State of California, Department of Mental Hygiene, Private Institutions Licensing Act, p. 5.

[45]State of California, Department of Mental Hygiene, Private Institution Licensing Act, p. 5.

[46]State of California, Department of Mental Hygiene, Private Institution Licensing Act, p. 8.

retarded patients who require supervision and who are provided with an organized program of services.[47]

(o) Facility. The terms institution and facility are used interchangeably and include the term "home."[48]

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[47]State of California, Department of Mental Hygiene, Private Institution Licensing Act, p. 8.

[48]State of California, Department of Mental Hygiene, Private Institution Licensing Act, p. 5.

Chapter 2

RELATED RESEARCH

A review of the literature from 1950 to 1971 revealed no survey studies concerning available community residences for the mildly retarded. However, reports of individual programs indicated some common characteristics among programs.

An experiment in thirty-day, temporary institutional treatment was undertaken in which trainable and educable mentally retarded, ages six to forty-two, enrolled in educational and recreational programs. Questionnaires directed to the parents of the retarded, were used to evaluate the effects of the short-term program on students. In an enthusiastic and positive response, parents reported behavioral improvements in their children. This study suggested the benefits that might be derived from a structured group-living experience.[1]

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[1]Bulent Tunakan, Charles R. Van Fleet, and Norma G. Johnson, Use of Community Boarding Houses as Transitional Living Facilities in Vocational Rehabilitation of Mental Hospital Patient-Clients (Omaha, Nebraska: University of Nebraska Medical Center, Nebraska Psychiatric Institute, May, 1970).

Tunakan, Van Fleet, and Johnson in a 1970 study hypothesized that psychiatric patients could be successful in the community if they were transferred to boarding houses within walking distance of the state institution and given supportive services. Among the clients in this program, three groups were identified: the successful group, the failure group, and the in-boarding home employed group. Persons in the last groups spent most of their time in the house and almost no time in the community except at their jobs. Their greatest needs were judged to be therapeutic support and structured living with supervision. For these psychiatric patients, the boarding house was a habilitative measure.[2]

An in-depth exploratory and evaluative survey was made of Rutland Corner House, a transitional home for psychiatric females who had been released from a state mental hospital. The hypothesis that the residents who formed satisfying personal relationships with only the director would have adequate post-house adjustment was shown to be statistically insignificant. In a related aspect of the study, women who did not relate to their sister residents also had inadequate post-house adjustment.

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[2]State of California, Department of Mental Hygiene, Mental Health Services in the Sacramento Valley and Northeastern California, A Mental Health Planning Study (Sacramento: State of California, 1968), p. 135.

In this study, socialization was shown to be related to post-house adjustment.[3]

The Newark State School Community Residence Unit was created to give mental retardates physical and psychological separation from the State School. The Residence Unit was located in an urban area, with a sheltered workshop nearby, and a wealth of recreational activities for members' leisure time. During a twenty-five month period, twenty-four mental retardates entered, left or remained in the Unit. Enrollees met these criteria: (a) were males with minimum ages of seventeen years, (b) had IQ's of seventy-five or lower, (c) had the ability to function in a workshop, and (d) had a prognosis for independent living. At the end of twenty-five months, eight returned to the State School or to their own homes as dependent persons, six were returned to the community because they were able to function independently, and ten remained in the Unit. Analysis of the factor "time spent at the institution" showed that the habilitated group averaged four years longer at the institution than the returned group. The returned group showed marginal success prognosis before enrollment. Their personality inadequacies became more obvious in the Unit. Of the

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[3]David Landy and Milton Greenblatt, Halfway House (Washington, D.C.: Government Printing Office, 1965).

25 percent that were habilitated, all were rated as having a potential for independent living.[4]

Between 1949 and 1958, Pacific State Hospital near Los Angeles discharged 110 retarded patients who had demonstrated prognosis for independent living through their participation in a habilitation program. Out of this group, forty-eight ex-patients were studied to examine the workings of their everyday lives. IQ's ranged from forty-eight to eighty-five; the mean age was 34.6 years. A conclusion in the study was that former patients saw themselves as ineffective and vulnerable. Every ex-patient had a benefactor upon whom he could rely in case of trouble. As confidents, the single most important function of the benefactors was the job of denying the retardates' feelings of impotence.[5]

In a study of state institutions for the mentally retarded, an hypothesis was posited that in effective institutions retardates would derive greater interpersonal contacts from normal adults than would retardates in ineffective institutions. In the study, an effective institution was described as an institution in which

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[4]Melville J. Appell, "A Residential Program for Retarded Males in a Community Setting," American Journal of Mental Deficiency, 68 (July, 1963), 104-8.

[5]Robert B. Edgerton, The Cloak of Competence.

retardates were happy and self-sufficient, showed intellectual growth, manifested minimal stereotypy such as thumb-sucking and rocking, and manifested no excessive need for social reinforcement. In the most effective facility, attendants and other non-retarded adults interacted as frequently with the residents as the residents interacted with each other. As the rated effectiveness of the institution diminished, peer contacts constituted a relatively greater source of interpersonal relations. This facet of the project also showed that on a purely statistical basis, non-retarded, non-attendant personnel (e.g., volunteers, professionals, physical therapists) interacted to a much higher degree with retardates than did the attendant personnel. Working retardates were the least important sources of interpersonal contacts for other retardates. The study recognized the need for specialized personnel free of housekeeping and administrative duties who could maintain human relations with the retardates.[6]

In a 1969 study, female enrollees in a state hospital met the following criteria in an experimental residential program: they were between thirty and fifty years old, had good work records in the hospital, and

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[6]Michael M. Klaber, Retardates in Residence, A Study of Institutions SRS RD 1816 (Washington, D.C.: Government Printing Office, n.d.).

were known for their trustworthiness and dependability. Comprehensive guidance and training for independent living were a part of the program. The women prepared some meals, decorated their rooms, and bought their own linens and furnishings with earnings from community jobs. Out of fourteen enrolled, one failed, three moved into the community, one moved to a halfway house in another city, and the others remained in the program. The program experienced no serious trouble among the residents or from the community.[7]

The report of an independent living unit in Connecticut stated that twenty-one out of forty-three residents had been placed successfully in the community after an eighteen-and-a-half month period.

> In order to be eligible for residence on this unit a man must be employed either at the School or in the neighboring community. Residents have single rooms and grounds privileges. They use the same recreational facilities as the school employees and eat their meals with them. They assume full responsibility for their own personal care, the use of their leisure time, and for punctuality. Instruction and experience in the handling of personal finances are provided.[8]

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[7]Oliver F. Graebner, "Post Oak Village Campus Half-Way Cottages," The Training School Bulletin, 66 (November, 1969), 127-32.

[8]Nicholas J. D'Aluisio, "Independent Living: Halfway House to Community Placement," cited by Mental Retardation Abstracts, 5:1 (1968), abstract number 506.

British experience with Hostels has been reported as extending over twenty years. Thirty to 60 percent of the clients have been returned to hospitals for a time, only to be tried out in Hostels again later. External services and facilities were reported available to the clients and, whenever possible, were paid for by the patients themselves. The Scott Road Hostel has been in operation for twenty-two years.

> During this period 362 patients were admitted (in 400 admissions) and of these, 88 patients have had to be returned to hospital (on 129 occasions); 227 were discharged, and most can be presumed to be leading satisfactory lives. Though there are only 14 beds in the Hostel, some 30 to 40 patients are usually on the register (30 in May 1964); half therefore are already living and working in the community outside the Hostel and can expect their discharge. Looking at the figures, one may say that rather less than a third of admissions had to be re-admitted to Hospital in the past 22 years (129 out of 400), though counted as patients, the figure is about a quarter (88 out of 362).[9]

A manual developed from the experiences of the Marbridge Community Living Centers suggested graduated stages of independence in a halfway house training program. Clients progressed from Novice to Graduate with increasing responsibilities. Rank eligibility requirements included progressively more savings as the client attained

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[9]F. J. S. Esher, "On Hostels for the Subnormal," International Copenhagen Congress on the Scientific Study of Mental Retardation, ed. Jacob Øster, II (Denmark: Det Berlingske Bogtrykkeri, 1964), 690-2.

higher rank. At Marbridge House of Dallas seventeen clients were drawing state assistance and seventeen were self-supporting. The Texas Vocational Rehabilitation Commission paid over twenty thousand dollars in one year for the tuition of the seventeen, while all thirty-four young men during a year earned a combined total of over $110 thousand from their jobs. The director recommended that a client stay for a period of at least two years.[10]

In 1969, the report of an operational residence in Bridgeport, Connecticut, described a shift toward the mildly retarded as prospective clients, and away from the moderately or severely retarded as clients.[11] Originally designed for a local population of retardates, the program had come to serve a population of retardates coming out of a state institution.[12]

A followup of the ex-patients in an occupational training center for young adults whose average IQ was fifty-five indicated a permanent employment rate of

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[10]J. E. Bridges, Establishing and Operating Community Living Centers for Mentally Retarded Adults (n.p.: n.p., n.d.), pp. 21-3, n. J. E. Bridges, President, Marbridge Foundation, Inc., P. O. Box 3570, Austin, Texas 78704.

[11]Louis H. Orzack et al., Residential Programming and Residential Center for the Mentally Retarded: The Experience in Bridgeport (Bridgeport, Connecticut: n.p., 1969), p. 18.

[12]Orzack, p. 39.

50 percent.[13] In a state program exploring the value of Department of Rehabilitation methods for the mildly retarded, 44 percent of the retarded clients were successfully moved from a status of unemployment to employment.[14] A two-year training program to teach independent living skills indicated that 23 percent of the clients were vocationally rehabilitated. In this group, more than 42 percent of the clients were below the educable range.[15] In West Virginia, 171 girls between the ages of sixteen and twenty-one, IQ's fifty to seventy-five, were enrolled in a short-term course to teach social and personal skills. Seventy-three percent completed the course, and 27 percent of the original group went on to complete more complex training.[16] These programs have

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[13]Edwin A. Hastbacka, Final Project Report: Development of an Occupational Training Center for the Mentally Retarded (Washington, D.C.: n.p., June 30, 1966), n. Educational Reproduction Service, ED 026 770, cited by Vocational Education and Work Study Programs (Arlington, Virginia: The Council for Exceptional Children, September, 1969), p. 12, resume i.

[14]State of California, Human Relations Agency, Department of Rehabilitation, Cooperative Programs: A Report to the Legislature, ed. Russell L. Forney (Sacramento: State of California, 1969), pp. 2-3, n. section on mental retardation.

[15]Elias Katz, An Independent Living Rehabilitation Program for Seriously Handicapped Mentally Retarded Adults (n.p.: San Francisco Aid, Retarded Children, 1965), p. 1, n. Educational Reproduction Service, ED 022 270.

[16]Richard Kelly, "West Virginia Project: Eight-Week Adjustment and Evaluation Course," Rehabilitation Record, July-August, 1965, p. 26.

shown how retardates can benefit from training.

Existing training programs and the absence of training programs have been criticized. The effectiveness of a hospital training program was questioned when about 50 percent of the ex-patients were found to have adjusted on own resources, without specific professional help.[17] Sparks and Younie also concluded that adjustment of some retardates has not in the past come about because of any significant programs devised by society.[18] In a State of California pamphlet, a task force concluded

> While there has been an increasing number of persons released each year from the hospitals,* there is lack of comprehensive evaluation of release programs, so little is actually known as to what gains, if any, are made; which programs produce best results; and which experiences in the hospital contribute most to progress in the community.
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> *Patients on leave of absence have increased from 2,500 in 1964 to 4,800 in 1969.[19]

Conclusions from related studies suggested features which administrators might consider for use in new programs.

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[17] Wolfson, pp. 20-3.

[18] Howard L. Sparks and William J. Younie, "Adult Adjustment of the Mentally Retarded: Implications for Teacher Education," Exceptional Children, 36:1 (1969), 13-8.

[19] State of California, Department of Mental Hygiene, An Action Program for the Mentally Retarded in California, p. 31.

Hoffman, in a 1970 study of post-hospital adjustment trends, presented an instrument which he claimed had an 80 percent success rate in predicting retardates' long-term potential for independent living. Hoffman's instrument was based on regression equations which utilized items from clients' past history. Out of 126 variables, more than thirty-two were found to be significant at less than the .05 level of confidence. Relationship with peers, year of discharge, and emotional stability were highly significant.[20] Other studies have also predicted future behavior on the basis of past functioning. Vogel, Kun, and Meshorer compared two groups of thirty subjects each, mean MA 8.8, IQ 60.3. The successful group had maintained itself outside the institution for a period of one year, while the unsuccessful group had been reinstitutionalized prior to one year in the community. In the study, MA, IQ, personal skills, and social and emotional behavior failed to differentiate the groups. However, lack of psychiatric disability during the hospital stay and good job performance in the community were found to be related to

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[20]John L. Hoffman, An Investigation of Factors Contributing to Successful and Non-Successful Adjustment of Discharged Retardates (Pownal, Maine: Pineland Hospital and Training Center, 1969), p. x.

postdischarge success, and were strong predictors of personal effectiveness.[21]

SUMMARY

Research literature concerning community residences for the mildly retarded has been limited. The literature does show, however, that many community residences were associated with, or directed by, state hospitals for the retarded. Success ratios of 20 percent and more were indicated, although one source suggested that 50 percent of the educable retarded at large achieve marginal independence with no special intervention on the part of society. The lower percentage mentioned for the ex-hospital group might be explained by the fact that the hospital educable retarded represented that portion of educable groups which did not adjust in the first place.

The clients reported in these studies were usually educable mentally retarded in their twenties and thirties. The populations in reported facilities ranged between ten and twenty persons. Programming emphasized training for social and vocational skills, and enhanced community participation. Clients with emotional or psychological

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[21]William Vogel et al., "Determinants of Institutional Release and Prognosis in Mental Retardates," Journal of Abnormal Psychology, 74 (December, 1969), 685-92; Kidd, 71-2.

disturbances were not enrolled in these programs.

The success of community residences has proceeded without benefit of a technology of community residences. A recently developed screening instrument by Hoffman has shown promise in helping the profession better utilize existing resources by differentiating retardates on the basis of their potential for long-term success in the community.

Chapter 3

DESIGN AND PROCEDURE

THE POPULATION

The investigator planned a mailing of form letters in order to discover where community residences were located. The letter of inquiry (Appendix B) requested the addresses of halfway houses involved in the habilitation of the mildly retarded. In this way, the investigator attempted to confine the population to homes serving higher-functioning retardates.

Initially, the investigator determined who should receive the letter of inquiry. A search for community residences had to include those states active in mental retardation services. The criterion used to determine activity was a United States military directory.[1] The directory listed all educable retarded classes within a fifty mile radius of military bases in the United States

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[1]U.S., United States Dependents Schools European Area, Education and Training Directory of Special Education Classes. CONUS and Overseas, ed. Joseph A. Mason (Washington, D.C.: Government Printing Office, April, 1968), n., Educational Reproduction Service, ED 018 060.

as of 1968. The investigator tabulated the list of states in this directory and retained for the study a list of eighteen states having fifty or more educable retarded classes. The names and addresses of persons responsible for the mental retardation activities in these eighteen states were then located in the Directory of State and Local Resources for the Mentally Retarded.[2] To this list of names the investigator added the names of the directors of the Associations for Retarded Children in each of the eighteen states. Other directories indicated those states offering wide ranges of mental retardation services, and supplied the names of programs within the states which the investigator either suspected to be community residences or suspected were operating community residences.[3] References in the literature and information from the investigator's personal correspondence were also included in the list of addresses to receive the letter of inquiry. At the time of the mailing, the list included thirty-two states representing 82 percent of the United States population.[4]

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[2]U.S., Department of Health, Education, and Welfare, Directory of State and Local Resources for the Mentally Retarded.

[3]See footnote 21 in Chapter 1.

[4]U,S., Department of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1970 (91st ed.; Washington, D.C.: Government Printing Office, 1970), p. 12.

Ninety-eight addresses were included: four Federal Government, eighteen private groups thought to be community residences, twenty Associations for Retarded Children, and fifty state offices (Appendix C).

The letter of inquiry was mailed on February 7, 1971. By March 6th, the investigator had received a response of forty-four percent and 118 referrals.

Use of the term "halfway house" in the letter of inquiry and in the investigator's personal correspondence elicited mixed reactions from respondents. These responses affected the next stage of the study in which the investigator had planned to conduct a random sampling of residences referred on the basis of the letter of inquiry. Some responses showed that the term "halfway house" had not been understood and that therefore some of the 118 referrals might not conform to the internal delimitations of the study. However, until the assessment of programs was accomplished, inappropriate programs could not be identified. Also, since returns of 10 percent in mail questionnaires are not uncommon, the investigator did not wish to reduce the size of the mailing and risk reducing the number of returns. Therefore, all 118 addresses in the group were retained for later investigation.

In response to the letter of inquiry, no one identified halfway houses for the mentally retarded in California. However, a system of Family Homes (F Homes)

and Resident Facilities (R Facilities) in California are licensed for the care of retardates.[5] The absence of halfway houses in the most populous state in the country caused the investigator to speculate that perhaps some F Homes and R Facilities were functioning as halfway houses for the mildly retarded. The code under which F Homes and R Facilities are administered does not utilize the term "habilitative" residence nor does it specify that specific facilities serve specific levels of retardation.[6] However, the code does stipulate that facilities ". . . conduct organized programs of purposeful activities in accordance with the interests, abilities, and needs of the patients."[7] Since facilities were expected to be engaged in purposeful activities, the investigator concluded that an assessment of their programs might be useful. Were these purposeful activities habilitative?

A State directory listed fifty-nine F Homes and six R Facilities which served the ambulatory adult retarded.[8]

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[5]State of California, Department of Mental Hygiene, Private Institution Licensing Act, pp. 1-41.

[6]State of California, Department of Mental Hygiene, Private Institution Licensing Act.

[7]State of California, Department of Mental Hygiene, Private Institution Licensing Act, p. 15.

[8]State of California, Department of Mental Hygiene, Division of Local Programs, Private Institutions Licensed by Department of Mental Hygiene (Sacramento: State of California, November 1, 1970).

These residences represented 9.4 percent of the facilities licensed to serve the mentally retarded and listed in the directory.

F Homes are limited to no more than six patients, but the capacity of the fifty-nine F Homes serving the ambulatory adult retarded totaled only 210 patients. This was because the majority of F Homes served fewer than six patients: 10 percent served one patient, 27 percent served two, 7 percent served three, 22 percent served four, 10 percent served five, and 22 percent served six patients. In a random stratified sampling of these homes in the directory, the investigator selected nineteen F Homes, or 35 percent of the F Homes which served the ambulatory adult retarded. The decision to take a sample of nineteen allowed for a nearly whole number representation from F Homes of every patient capacity.

The directory listed only six R Facilities serving the ambulatory adult retarded and having patient capacities less than sixty-one. Four R Facilities were randomly selected from this group.

Approved Board and Care Homes (ABC Homes) also care for retarded persons in California. The investigator was unable to locate a statewide listing of ABC Homes. State officials in Fresno, California and Porterville, California supplied the investigator with the names of five programs

in Fresno and Tulare Counties. These programs were said to serve the more capable adult retarded.

In all, twenty-eight programs were included in the list of California addresses. This list was combined with the referrals resulting from the letter of inquiry to make up a total listing of 146 addresses.

COLLECTION OF DATA

The identification and evaluation of programs proceeded in three stages: (a) questionnaires were mailed to the 146 addresses; (b) returned questionnaires which conformed to the internal delimitations of the study were assembled for statistical consideration; and (c) data were treated statistically.

Data were collected by a mail questionnaire. The method of addressing and mailing the questionnaire was adapted from that of a mail questionnaire used in January, 1971 by Closer Look, a United States public information agency for exceptional children.

The questionnaire used in this study (Appendix E) consisted of four pages which were glued together at their upper margins. The first page was the cover letter (Appendix D). Each letter was signed by the investigator, had a personally written note stating how the investigator had obtained that address, and an offer to send respondents

the results of the study. Printed on the second two pages was the body of the questionnaire. The questionnaire format was made up of multiple choice, check list, fill-in, and open-ended questions.

When the questionnaire was folded, the last page became the envelope. It bore an adhesive tag for sealing, a postage stamp for first class mailing, the address of the sender, and the address of the investigator.

On Saturday March 6, 1971, 146 questionnaires were posted by first class mail. Within ten days, 31 percent of the facilities had responded. At that time, the investigator mailed additional questionnaires with new cover letters to non-respondents. Cover letters in the second mailing were not personally signed, did not indicate where the investigator had obtained the addresses, and did not include an offer to send results to the participants (Appendix F). This group of questionnaires was sent by third class mail.

Approximately one month after the first mailing, the investigator collected returned questionnaires for computer processing. By that date, April 2nd, 51 percent of the questionnaires had been returned. Fourteen California Programs and forty-two other programs had responded with completed questionnaires which met the internal delimitations of the study. Questionnaires

continued to be received after the deadline for submitting data to the computer center. By April 23rd, 66 percent of the questionnaires had been returned. Unless otherwise indicated in the study, computer generated data was revised to include late returns.

TREATMENT OF DATA

The addresses of residences which appeared in Appendix G represented all addresses mailed questionnaires. The addresses of residences were included in the Appendix if they were mailed a questionnaire and did not respond, if they responded and met the internal delimitations of the study, or if the address was received after the mailing of the questionnaire. The names of programs administered by state offices were considered public knowledge and were listed in the Appendix. However, where respondents had requested that correspondence be conducted through official channels and not directed to community residences, the addresses of the responsible agencies were given instead of the actual residence addresses.

The data transmittal forms used in the study were compact representations of the raw data derived from the questionnaires (Appendix I). On the data forms, one horizontal row of numbers represented the raw data from one residence. The meanings assigned to the columns

on the data forms were indicated in Appendix H. Some data which appeared on the data forms were not taken directly from the questionnaires, but rather were calculated from the questionnaires. The cases where calculation occurred are explained below.

The ratio between mentally ill and mentally retarded in residences was presented in columns five, six, and seven of the data transmittal forms. These figures were derived by dividing the number of mentally ill in a residence by the number of mentally retarded. Summing the numbers which appeared on item nine of a questionnaire gave the number of retarded in a residence.

Numbers in columns ten and eleven indicated the mean IQ of residents. These numbers were derived by summing the IQ's supplied on item four and dividing the sum by the number of IQ's furnished.

Columns twenty-four through twenty-nine corresponded to questionnaire item ten and were reserved for the percentage of residents who went to school, to work, or both without help. To economize on computer usage, each of these measures was permitted a possible maximum of 99 percent. The percentages were derived by dividing the number of retarded engaged in these activities by the total number of retarded in the residence.

Questionnaire item twelve asked respondents to check each of the following which were within a twenty

minute walk of the residence: park, library, church, or public amusement. Where questionnaires showed that two or more of these buildings were within a twenty minute walk, the numeral one was placed in column thirty on the data transmittal form. Where residences were shown to have fewer than two such places, a two was placed in column thirty.

Numbers in columns thirty-one through forty represented percentage of residents using public facilities, percentage helping with duties in the residence, percentage making their own beds, percentage washing their own clothes, and percentage paying their own rent. Each measure was permitted a maximum of 99 percent.

The percentage using public facilities was shown in columns thirty-one and thirty-two and was determined in the following way. Questionnaire item twelve asked for the number of residents traveling on their own to public parks, libraries, churches, or public amusements. In order for a facility to score the maximum of 99 percent on this measure, all residents had to regularly go to all places mentioned. The percentage using public facilities was calculated by summing the number of residents going to each place and then dividing by the possible maximum for the residence. To take an example, if four could go to parks on their own, none went to a library, twenty-five

went to church, and twenty-five used public amusements, then the sum of the numbers was fifty-four. If the number of retarded in the residence was shown as twenty-five, then the possible maximum on this measure was four times twenty-five, or one hundred. Therefore, the percentage of residents using public facilities was fifty-four divided by one hundred, or 54 percent.

The percentage involved in household duties was determined in a similar way. The numerator used in this case, however, was the number of residents who washed dishes, vacuumed, cleaned the bathroom, and helped with yard work on a regular basis.

Marginal notations on the returned questionnaires showed that sixteen programs outside California were less than twelve months old. Respondents estimated or projected some figures supplied on these returned questionnaires, as indicated by written comments. Since new programs represented 30 percent of the programs outside California, the new programs were set aside to be considered as a separate group. Three kinds of programs were then involved in the analysis of the data: California Programs, Old Programs, and New Programs.

Frequency distributions in Chapter 4 were constructed to indicate the questionnaire responses of each group. The scores in wide range distributions were

collected so as to indicate the overall pattern of the data. Frequency distributions in this study were analyzed and found to be skewed for nearly every measure. Because of this, and because the widest distributions only involved ranges between zero and thirty-seven, the investigator presented only mean values with the frequency distributions. The distributions appeared according to their sequence in the questionnaire. Exceptions were the Q sorts of two open-ended items on the instrument, and a Q sort of written comments on the instrument.

The Pearson product-moment correlation coefficient and point biserial correlation for dichotomous variables were presented to describe the ways that selected distributions varied in respect to each other. The point biserial correlation was a computer program which permitted correlational statistics to be calculated for questionnaire item twelve, the availability of public buildings.

Chapter 4

ANALYSIS OF RESULTS

The majority of New Programs were found in two states: 19 percent in Florida and 34 percent in Texas. The others were located throughout twelve states. Seven programs were operated by state hospitals for the mentally retarded, four of which were found in New York State.

The mean number of persons in California F Homes was five, and in 13 percent of these homes patients were both men and women. Of the two R Facilities which returned questionnaires, one reported eighteen clients in the facility, and the other reported twenty-five clients. Both facilities served men and women. The mean IQ in F Homes and R Facilities was 52. No residence reported that more than 25 percent of their patients went to school, to work, or both, and twelve out of fourteen said none of their patients engaged in these activities. Over one-fourth of the residences had no park, church, library, or public amusement within walking distance, i.e., within a twenty minute walk. Where public facilities were available, six out of eight residences reported less than 10 percent

of their patients using the facilities alone, while two reported usage in excess of 50 percent. In two homes, 50 percent or more of the patients paid rent out of their own pockets, and in nine out of fourteen, residents paid no rent at all. Fifty-nine percent of the patients participated in household duties, 81 percent made their own beds, and 15 percent washed their own clothes. The questionnaire asked what the typical length of stay was. Four out of fourteen reported from two to four years, and ten said more than five years, "indefinitely," or "for life." The mean length of stay was fifty-five months in those cases where respondents supplied definite figures on the questionnaire.

Old Programs had client populations of twenty-four. Eleven out of thirty-seven residences housed both men and women in the same facility. The mean IQ in Old Programs was sixty-one. In this group, 98 percent of the clients were going to school, work, or both. Almost 14 percent of the residences had no public facilities within walking distance. Twenty-seven percent of the facilities said that clients used all available public facilities, while the rest reported between 15 and 70 percent usage. The mean score for all Old Programs was 60 percent use of available community facilities. In these programs, about 60 percent of the clients paid rent out of their

own pockets. Fifteen Old Programs said that all clients paid something toward rent. Client participation in household duties was 93 percent. Eighty-eight percent made their own beds and 76 percent washed their own clothes. The questionnaire asked, "Typically, how long do they stay with you?" Four Old Programs stated "indefinitely," or more than five years, but thirty-two reported stays from four to forty-eight months. The mean length of stay for thirty-seven programs was twenty-two months.

New Programs were able to supply only limited information. Many were less than six months old and three had reported opening during the prior month. The mean number of clients was twenty. Six New Programs were segregated by sex and ten were not. The mean IQ for fifteen New Programs was sixty-three. No program in this group estimated that their clients would stay over twenty-four months, and the mean on this item was ten months. Over 80 percent of the respondents estimated that clients would eventually be able to use 100 percent of the community facilities mentioned in the questionnaire.

The questionnaire asked about the characteristics of clients who failed in the program. Respondents reported that 14 percent of the failures had low IQ's, 18 percent had other problems besides mental retardation, and 68 percent had emotional disturbances, or social and

behavioral adjustment problems. In reply to the question on the characteristics of clients who left to live more independently, directors reported that 12 percent married, 12 percent had higher IQ's, 24 percent other reasons, and 52 percent had higher social ability, greater independence and maturity, or were able to take part and profit from the program. Comments about the traits of clients were similar among the three program groups.

A point biserial correlation between the factors (a) public buildings within a twenty minute walk and (b) percentage of clients using public facilities by themselves was significant at the .01 level of significance for New Programs. Pearson's correlation matrix for length of stay, percentage of clients using public facilities, and percentage of clients paying rent indicated that length of stay and percentage using public facilities were significantly correlated at the .01 level of significance for Old Programs. When this matrix was calculated for California Programs, no significant correlations were found. Pearson's correlation for IQ and length of stay for the composite of all programs indicated no significance at the .05 level of significance. Scatter plots between IQ and the following variables indicated zero correlations: patients using public facilities on their own for California Programs, and residences where clients did not

use public facilities for all programs. These findings and the comments of directors on the traits of their clients who succeeded seemed to agree with the idea that social skills are more related to success in independent living than are intellectual assessments.

In more than 75 percent of the cases, California and Old Programs were segregated by sex. The IQ's of persons in California Programs were judged lower than those in the other programs. Mental retardates in Old Programs predominantly went to school or to work, while retardates in California Programs usually engaged in none of these activities. Where public facilities were within walking distance, the majority of patients in California Programs did not use the facilities by themselves. In both other programs, clients used public facilities to a much greater degree. Thirteen percent of the retardates in California Programs paid a part or all of their rent out of their own pockets. Sixty percent of the clients in Old Programs paid a part or all their rent out of their own pockets. When patients became residents of California Programs, they tended to stay indefinitely. In Old Programs, the median on length of stay was sixteen months, the mean was twenty-two months. In California Programs, the mean number who left to live more successfully during the prior three years was calculated at 0.32 persons.

In Old Programs this mean value was six persons.

Over 30 percent of the programs outside California were New Programs. Their directors assigned the New Program clients the highest mean IQ in the three groups of programs. Many of the figures supplied for this group were indicated as estimates. Where programs were less than one month old, the frequency distributions for the programs also included projections on the part of program directors.

TABLE I

SUMMARY OF THE RESULTS ON THE QUESTIONNAIRE

	California Programs	Old Programs	New Programs
Number of Residences	15	37	16
Mean Length of Stay, Months	55	22	NA
Mean IQ	52	61	63
Mean Number of Male Residents	3.7	14	12
Mean Number of Female Residents	5.4	10	8
Mean Number of Males to Leave as Successful	0.22	6.0	NA
Mean Number of Females to Leave as Successful	0.43	6.0	NA
Mean Number of Males to Leave as Unsuccessful	0.50	3.4	NA
Mean Number of Females to Leave as Unsuccessful	0.36	3.5	NA
Ratio of Residences Integrated by Sex to Number of Residences in the Group	0.13	0.27	0.63

TABLE I (CONTINUED)

	California Programs	Old Programs	New Programs
Mean Percentage Going to School	10	27	21
Mean Percentage Going to Work	5	58	38
Mean Percentage Going to School and Work	3	2	22
Percentage of Residences that Have Public Buildings Within a 20 Minute Walk	72	87	87
Mean Percentage of Residents Using Public Buildings	37	60	66
Mean Percentage Helping with Upkeep of Residence	59	93	87
Mean Percentage Making Own Beds	81	88	99
Mean Percentage Washing Own Clothes	15	76	79
Mean Percentage Paying Rent out of Own Pockets	13	60	45

TABLE II

FREQUENCY DISTRIBUTIONS ON CALIFORNIA RESIDENCES

Item	Response	Frequency	N	Mean
Length of Stay, Months	60	9		
	48	3		
	24	1	13	54.5
Estimated IQ	80	1		
	75	1		
	70	1		
	62	1		
	60	1		
	55	3		
	50	1		
	45	1		
	25	3	13	52
Male Patients Who Left as Successful, Number of Persons in Last Three Years	1	3		
	0	11	14	0.22
Female Patients Who Left as Successful, Number of Persons in Last Three Years	2	1		
	1	4		
	0	9	14	0.43
Male Patients Who Left as Unsuccessful, Number of Persons in Last Three Years	4	1		
	2	1		
	1	1		
	0	11	14	0.50
Female Patients Who Left as Unsuccessful, Number of Persons in Last Three Years	2	1		
	1	3		
	0	10	14	0.36

TABLE II (CONTINUED)

Item	Response	Frequency	N	Mean
Number of Males Who Live in the Residence	14	1		
	6	5		
	5	2		
	2	1		
	0	7	15	3.7
Number of Females Who Live in the Residence	34	1		
	19	1		
	6	3		
	4	2		
	1	2		
	0	6	15	5.4
Percentage of Patients Who Go to School Without Help	60	1		
	50	1		
	19	1		
	6	2		
	0	9	14	10
Percentage of Patients Who Go to Work Without Help	50	1		
	14	1		
	6	1		
	0	11	14	5
Percentage of Patients Who Go to School and Work	31	1		
	6	1		
	0	12	14	2.6
Public Buildings Within a 20 Minute Walk of the Residence	Yes	10		0.72
	No	4	14	0.28

TABLE II (CONTINUED)

Item	Response	Frequency	N	Mean
Percentage of Patients Using Public Buildings on Their Own	99	4		
	75	1		
	31	1		
	6	1		
	0	7	14	37
Percentage of Patients Involved in Household Duties	99	6		
	75	1		
	50	1		
	49	1		
	27	1		
	21	1		
	8	1		
	0	2	14	59
Percentage of Patients Who Make Their Own Beds	99	8		
	95	1		
	72	1		
	60	1		
	40	1		
	0	1	14	81
Percentage of Patients Who Wash Their Own Clothes	99	1		
	89	1		
	60	1		
	18	1		
	0	10	14	15
Percentage of Patients Who Pay Rent Out of Their Own Pocket	99	1		
	50	1		
	17	1		
	15	1		
	3	1		
	0	9	14	13

TABLE III

FREQUENCY DISTRIBUTIONS ON OLD PROGRAMS

Item	Response	Frequency	N	Mean
Ratio of Mentally Ill to Mentally Retarded	2.11-2.40	1		
	1.81-2.10	0		
	1.51-1.80	1		
	1.21-1.50	0		
	0.91-1.20	1		
	0.61-0.90	0		
	0.31-0.60	0		
	0.00-0.30	33		
	(i=0.30)		37	0.20
Length of Stay, Months	58-60	4		
	50-57	0		
	43-49	2		
	36-42	3		
	29-35	1		
	22-28	4		
	15-21	6		
	8-14	8		
	0- 7	8		
	(i=7)		36	22
Estimated IQ	69-77	11		
	60-68	13		
	51-59	7		
	42-50	3		
	33-41	3		
	(i=9)		37	61
Male Clients Who Left as Successful, Number of Persons in Last Three Years	26-30	1		
	21-25	1		
	16-20	3		
	11-15	5		
	6-10	3		
	0- 5	24		
	(i=5)		37	6.0

TABLE III (CONTINUED)

Item	Response	Frequency	N	Mean
Number of Females Who Live in the Residence	41-50	1		
	31-40	2		
	21-30	2		
	11-20	6		
	0-10	26		
	(i=10)		37	10
Percentage of Clients Who Go to School Without Help	99	9		
	72	1		
	37	1		
	33	1		
	30	1		
	17	1		
	3	1		
	0	22	37	27
Percentage of Clients Who Go to Work Without Help	81-100	20		
	61- 80	1		
	41- 60	0		
	21- 40	3		
	0- 20	13		
	(i= 20)		37	58
Percentage of Clients Who Go to School and Work Without Help	99	6		
	37	1		
	2	1		
	0	29	37	1.7
Public Buildings Within a 20 Minute Walk of the Residence	Yes	32		87%
	No	5	37	13%

TABLE III (CONTINUED)

Item	Response	Frequency	N	Mean
Female Clients Who Left as Successful, Number of Persons in Last Three Years	26-30	2		
	21-25	2		
	16-20	2		
	11-15	2		
	6-10	4		
	0- 5	25		
	(i= 5)		37	6.0
Male Clients Who Left as Unsuccessful, Number of Persons in Last Three Years	20-22	1		
	17-19	0		
	14-16	3		
	10-13	1		
	7- 9	1		
	4- 6	4		
	0- 3	27		
	(i= 3)		37	3.4
Female Clients Who Left as Unsuccessful, Number of Persons in Last Three Years	46-50	1		
	41-45	0		
	36-40	0		
	31-35	0		
	26-30	0		
	21-25	0		
	16-20	0		
	11-15	2		
	6-10	3		
	0- 5	31		
	(i= 5)		37	3.5
Number of Males Who Live in the Residence	51-60	1		
	41-50	2		
	31-40	2		
	21-30	3		
	11-20	9		
	0-10	19		
	(i=10)		37	14

TABLE III (CONTINUED)

Item	Response	Frequency	N	Mean
Percentage of Clients Using Public Buildings on Their Own	91-100	12		
	76- 90	3		
	61- 75	4		
	46- 60	6		
	31- 45	3		
	16- 30	4		
	0- 15	5		
	(i= 15)		37	60
Percentage of Clients Involved in Household Duties	81-100	31		
	61- 80	1		
	41- 60	3		
	21- 40	4		
	0- 20	3		
	(i= 20)		37	93
Percentage of Clients Who Make Their Own Beds	99	30		
	86	1		
	50	1		
	25	1		
	5	1		
	0	11	36	88
Percentage of Clients Who Wash Their Own Clothes	99	25		
	91	1		
	70	2		
	50	1		
	29	1		
	5	1		
	0	6	37	76
Percentage of Clients Who Pay Rent Out of Their Own Pocket	81-100	17		
	61- 80	3		
	41- 60	4		
	21- 40	4		
	0- 20	9		
	(i= 20)		37	60

TABLE IV

FREQUENCY DISTRIBUTIONS ON NEW PROGRAMS

Item	Response	Frequency	N	Mean
Ratio of Mentally Ill to Mentally Retarded	0.36	1		
	0.20	1		
	0	13	15	0.04
Length of Stay, Months	Programs were too new to provide information.			
Estimated IQ	75	2		
	70	1		
	65	7		
	60	2		
	55	2		
	45	1	15	63
Number of Successful and Unsuccessful Clients Leaving in Last Three Years	Programs were too new to provide information.			
Number of Males Who Live in the Residence	21-25	2		
	16-20	2		
	11-15	3		
	6-10	8		
	0- 5	1		
	(i= 5)		16	12
Number of Females Who Live in the Residence	41-50	1		
	31-40	0		
	21-30	0		
	11-20	2		
	0-10	13		
	(i=10)		16	8
Percentage of Clients Who Go to School Without Help	99	3		
	7	1		
	0	11	15	21

TABLE IV (CONTINUED)

Item	Response	Frequency	N	Mean
Percentage of Clients Who Go to Work Without Help	81-100	4		
	61- 80	0		
	41- 60	1		
	21- 40	3		
	0- 20	7		
	(i= 20)		15	38
Percentage of Clients Who Go to School and Work Without Help	99	3		
	25	1		
	0	11	15	22
Public Buildings Within a 20 Minute Walk of the Residence	Yes	13		87%
	No	2	15	13%
Percentage of Clients Using Public Buildings on Their Own	91-100	5		
	61- 90	6		
	31- 60	1		
	0- 30	3		
	(i= 30)		15	66
Percentage of Clients Involved in Household Duties	91-100	10		
	61- 90	2		
	31- 60	2		
	0- 30	1		
	(i= 30)		15	87
Percentage of Clients Who Make Their Own Beds	99	14		
	90	1	15	99

TABLE IV (CONTINUED)

Item	Response	Frequency	N	Mean
Percentage of Clients Who Wash Their Own Clothes	99	10		
	90	1		
	50	1		
	0	11	15	79
Percentage of Clients Who Pay Rent Out of Their Own Pocket	81-100	5		
	61- 80	0		
	41- 60	2		
	21- 40	2		
	0- 20	11		
	(i= 20)		15	45

TABLE V

RESPONSES TO THE QUESTION, "WHAT WERE THE CHARACTERISTICS OF THOSE WHO LEFT TO LIVE MORE INDEPENDENTLY?"

Socially adept and mature	11
"Other reasons"	10
Got married	6
Higher IQ	5
Took advantage of program	4
More independent	4
Could fulfill program demands	4
No different	3
Went to a Co-op	2
Went home	2
Older	2
More drive	1
N=	54

TABLE VI

RESPONSES TO THE QUESTION, "WHAT WAS THE MAIN REASON CLIENTS COULD NOT BENEFIT FROM THE PROGRAM?"

Behavioral adjustment problems	14
Social problems	12
Emotional disturbance	6
IQ too low	6
Family influence	5
"Other problems"	5
Lack of motivation	2
Homosexuality	1
N=	46

TABLE VII

WRITTEN COMMENTS OF ALL PROGRAMS TO THE QUESTION, "TYPICALLY, HOW LONG DO THEY STAY WITH YOU?"

California Programs, N=5

"They stay as long as I can care for them and my home is a benefit to them--I have had them from 10 years stay until one who has been with me only five years."

"A man who came when we first opened our home (1965) is still with us. They seem to stay when they come. Seven years for one, none have left."

"Hopefully, the remainder of their lives."

"Indefinite."

"Full time with exception of going home briefly at Christmas."

New Programs, N=0

Programs were too new to supply data on this question.

Old Programs, N=11

Indefinitely	4
One to three years	3
Never over a year	2
Longer than a year needed	1
Life	1

TABLE VIII

REACTIONS TO THE TERM "HALFWAY HOUSE" IN THE LETTER OF INQUIRY AND IN THE INVESTIGATOR'S PERSONAL CORRESPONDENCE

	NARC'S	Private Groups	State and Federal Officials
Did not use the term	15%	33%	11%
Questioned the use of the term	15%	8%	22%
Used the term and did not question its use	70%	58%	67%
N	13	12	27

The following table summarizes a computer-generated point biserial correlation of two factors, availability or non-availability of public buildings within a twenty minute walk of the residence, and the percentage use of public facilities by the residents. Correlations were shown for California, Old, and New Programs.

TABLE IX

AVAILABILITY OF PUBLIC FACILITIES AND USE OF PUBLIC FACILITIES: PROGRAM CORRELATIONS

Program	Coef. (1X3)	T (1X3)	Coef. (2X3)	T (2X3)	df
California	-.492	-1.788	0.355	1.202	10
Old	-.250	-1.369	-.158	-.849	28
New	-.774*	-4.405	-.428	-1.706	13

1=Public buildings within a twenty minute walk of the residence.

2=Public buildings not within a twenty minute walk of the residence.

3=Percent of clients using public facilities alone.

*Significant at the .01 level of significance.

Table X summarizes pearsonian correlations for selected factors in California and Old Programs. The correlation between percentage use of public facilities and percentage of clients paying rent in Old Programs was significant at the .01 level. The same correlation for New Programs was not significant at the .05 level and was not evaluated at more than the .05 level. No correlations on length of stay were calculated for New Programs owing to their lack of history on this measure.

TABLE X

CORRELATION MATRIX: LENGTH OF STAY, PERCENTAGE USING PUBLIC FACILITIES, AND PERCENTAGE PAYING RENT

Program		Old				California			
		1	2	3	df	1	2	3	df
Coefficient 1	1.000	-.181	-.219	28	1.000	.085	-.113	10
T	1.000	-.974	-1.188		1.000	.269	-.361	
Coefficient 2		1.000	.598*			1.000	.332	
T		1.000	3.943			1.000	1.112	
Coefficient 3			1.000				1.000	
T			1.000				1.000	

1=Length of stay in months

2=Percentage of clients using public facilities

3=Percentage of clients who pay part or all their rent out of their own pockets

*Significant at the .01 level of significance

Chapter 5

SUMMARY AND CONCLUSIONS

The study was designed to determine the extent and location of community residences, the amount of resident involvement in home upkeep and self-maintenance, and the resident use of public facilities. The investigator defined a community residence as a facility of sixty or fewer persons in which the ratio of mentally ill to mentally retarded was less than three to one. The term "halfway house" was used synonymously with the term "community residence" and implied a considered plan to normalize the lives of retarded persons. An effort was made to confine the collection of programs to those residences either said to be engaged in the habilitation of the mildly retarded, or thought to be engaged in the habilitation of the mildly retarded.

A form letter was mailed to determine where community residences were located. The results of this mailing produced 118 referrals. No residences in California were referred on the basis of the letter, and no references to California-based programs were found in

the literature. The investigator concluded that perhaps some Family Homes and Residence Facilities in California were functioning as halfway houses for the mildly retarded. Therefore, a random sample of F and R residences was included in the list of referrals which resulted from the letter of inquiry. The final list was composed of 146 addresses.

Questionnaires were mailed to all addresses in order to assess programs and determine the characteristics of clients. The internal delimitations of the study were met by sixty-eight programs. Written comments on the questionnaires indicated that sixteen residences had been in operation for twelve months or less. Because some data on these returns were projected data, these questionnaires were considered a separate group. Three kinds of programs were then involved in the study: California Programs, New Programs, and Old Programs.

An analysis of the data indicated that the majority of programs outside California were located in Texas and Florida. Clients in Old Programs had short lengths of stay (mean of twenty-two months), used public facilities in about 60 percent of the cases, went to jobs independently in more than half of the cases, and contributed to their own maintenance in 60 percent or more of the cases. Old Programs indicated that about two clients a year moved away as successful, and that about one a year had to leave

as unsuccessful. In general, New Programs resembled Old Programs. New Programs differed markedly from all others, however, in that over 60 percent were integrated by sex. Otherwise, both New and Old Programs appeared to have normalizing training practices.

Although fifty-one halfway house residences were located in other states, the investigator was unable to discover one halfway house for the mildly retarded in California. California Programs were characterized by fewer residents, longer lengths of stay, lower estimated IQ, little community involvement, and a lower level of self-maintenance. Written comments on some questionnnaires from California Program directors indicated special efforts had been made for the benefit of patients. One respondent detailed extensive camping trips, and others indicated that residents frequently accompanied directors to town on shopping trips. Some California respondents added that residents were not merely patients, but had become members of the directors' families. The questionnaire, however, was designed neither to assess the normalizing effects of such activities nor to assess the potential adaptive behavior of patients. What was apparent was that patients were not normalized to the extent of residents in other programs.

Although the mean IQ in California Programs was fifty-two, five programs in thirteen assessed their patients' IQ's between sixty and eighty. On the questionnaire, patients in these programs did not evidence greater adaptive behavior than patients in other California Programs. What is the current status of programming for the higher grade retarded in California Programs? What are their adaptive behaviors? The investigator would hypothesize that research would indicate that adaptive behaviors are below professional expectations and that systematic programming for behavioral changes is virtually non-existent. The investigator inferred from the returned questionnaires that formal, ongoing training programs were more instrumental in promoting independence than were informal programs, or the absence of programs. This hypothesis could be tested in future studies.

A recurring impression in this study was that patients in California Programs had been assigned lower IQ's and lower adaptive behaviors because of lower expectancies on the part of California directors. Would the adaptive behaviors of mildly retarded patients be significantly changed from those of a mildly retarded control group, if, for the experimental group, directors were initially informed that their patients had strong prognosis for independent living? Opportunities for

training and directors' expectations of patients should be re-examined for California Programs.

This study has made available ample sources from which California officials might obtain both the inspiration and the technical direction necessary for the creation of halfway house programs for the mildly retarded. Suggestions have also been made for the enhancement of adaptive behaviors of California patients. If, indeed, no systematic service presently accomplishes the function of halfway houses in California, then the need for such services has been shown by default.

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APPENDIXES

APPENDIX A

Declaration of General and Special Rights of the Mentally Retarded

Declaration

OF GENERAL AND SPECIAL RIGHTS OF THE MENTALLY RETARDED

WHEREAS the universal declaration of human rights, adopted by the United Nations, proclaims that all of the human family, without distinction of any kind, have equal and inalienable rights of human dignity and freedom;

WHEREAS the declaration of the rights of the child, adopted by the United Nations, proclaims the rights of the physically, mentally or socially handicapped child to special treatment, education and care required by his particular condition.

Now Therefore

The International League of Societies for the Mentally Handicapped expresses the general and special rights of the mentally retarded as follows:

ARTICLE I: The mentally retarded person has the same basic rights as other citizens of the same country and same age.

ARTICLE II: The mentally retarded person has a right to proper medical care and physical restoration and to such education, training, habilitation and guidance as will enable him to develop his ability and potential to the fullest possible extent, no matter how severe his degree of disability. No mentally handicapped person should be deprived of such services by reason of the costs involved.

ARTICLE III: The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to productive work or to other meaningful occupation.

ARTICLE IV: The mentally retarded person has a right to live with his own family or with fosterparents; to participate in all aspects of community life, and to be provided with appropriate leisure time activities. If care in an institution becomes necessary it should be in surroundings and under circumstances as close to normal living as possible.

ARTICLE V: The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interest. No person rendering direct services to the mentally retarded should also serve as his guardian.

ARTICLE VI: The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If accused, he has a right to a fair trial with full recognition being given to his degree of responsibility.

ARTICLE VII: Some mentally retarded persons may be unable due to the severity of their handicap, to exercise for themselves all of their rights in a meaningful way. For others, modification of some or all of these rights is appropriate. The procedure used for modification or denial of rights must contain proper legal safeguards against every form of abuse, must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic reviews and to the right of appeal to higher authorities.

ABOVE ALL – THE MENTALLY RETARDED PERSON HAS THE RIGHT TO RESPECT.

APPENDIX B

Letter of Inquiry

FSC / SE-IMC

FRESNO STATE COLLEGE / SPECIAL EDUCATION - INSTRUCTIONAL MATERIALS CENTER

Lab School 171 Fresno, California 93710 (209) 487-1131

I am researching training practices in the habilitation of the mildly retarded. The study concerns itself with halfway house programs operating in communities.

The location of programs is a major problem in this research. National and state directories do not differentiate halfway houses from other residential programs for retarded citizens. As yet, no list of halfway houses has been found.

The list generated by my study will supply addresses needed for future research. The list will be submitted to the U.S. Office of Education for dissemination through ERIC, and will then be available in most major libraries throughout the country.

Your contribution to the address list will be greatly appreciated. Thank you for your help.

Yours very truly,

Gilbert P. Gia
Fellow in Mental Retardation
U.S. Office of Education

APPENDIX C

Addresses Mailed the Letters of Inquiry

In the following list of addresses an asterisk indicated that the agency responded to the letter of inquiry. Where addresses were underlined, the following address was the responding agency. The remaining addresses did not respond to the letter of inquiry.

APPENDIX C

Addresses Mailed the Letters of Inquiry

Arizona Association for
Retarded Children
Robert W. Shook, Ex Dir
2929 E Thomas Road, Rm 206
Phoenix, AZ 85016

Commission on Mental Retardation
State Department of Health
1624 W Adams St
Phoenix, Arizona 85007

Rehabilitation Services
DeWitt State Hospital
PO Box 192
Auburn, California 95603

*Ralph A. Hicks, Assistant Chief
Bureau of MR Services
Department of Public Health
2151 Berkeley Way
Berkeley, California 94704

Fairview State Hospital
2501 Harbor Blvd
Costa Mesa, California 92626

*Ruth E. Stiers, Coordinator
Council for Retarded Children
Child Development Division
PO Box 27707
Los Angeles, California 90027

Portals House, Inc.
PO Box 76118
Los Angeles, California 90005

*Richard S. Gates
Educations Operations
Madera Employment Training Ctr
19500 Road 28½
Madera, California 93637

*James W. Akers
Miramonte Mental Health Services
Palo Alto, California 94306

Pacific State Hospital
PO Box 100
Pomona, California 91769

Porterville State Hospital
R.V. Goodman, Admin
Porterville, California 93257

*James T. Shelton, MD
Medical Director

*Herbert Dörken, Chief
Division of Research and
Training
Bureau of Research
744 P St
Sacramento, California 95814

Manitoba School
Dr. Glen Lowther, Dir
Portage La Prairie
Manitoba, Canada

*National Institute on MR
National Reference Service
4700 Keele St
Downsview, Canada

Colorado State Dep of Instit
Division of MR
328 State Services Building
Denver, Colorado 80203

*State Home and Training School
10285 Ridge Rd
Wheat Ridge, Colorado 80033

*Maynard Hesselbarth, Dir
Laradon Hall
East 51st Av and Lincoln St
Denver, Colorado 80216

APPENDIX C (CONTINUED)

*Thomas P. Carroll, Ex Dir
Colorado Association for RC
1540 Vine St
Denver, Colorado 80206

*Department of the Army
Office for the Civilian Health
and Medical Program of the
Uniformed Services
Denver, Colorado 80240

Parents and Friends of MR
Children of Bridgeport, Inc.
4695 Main St
Bridgeport, Connecticut 06606

Connecticut ARC
Ann Switzer, Ex Dir
21-R High St
Hartford, Connecticut 06103

*Connecticut State Dep of Health
Office of MR
State Office Building, Rm 425
Hartford, Connecticut 06510

Arthur L. DuBrow
State Department of Health
79 Elm St
Hartford, Connecticut 06115

*Albert Evans, Dir
Social Services
Mansfield Training School
PO Box 51
Mansfield Depot, Connecticut 06251

New Haven Area Rehab Ctr
20 Brookside Ave
New Haven, Connecticut 06515

Commission on MR
Halfway House Programs
Department of Public Health
1825 Connecticut Ave, N.W.
District of Columbia 20001

Joseph P. Kennedy, Jr., Foundation
1411 K St, N.W.
Washington, D.C. 20005

District of Columbia Help for
Retarded Children
David Silberman, Ex Dir
405 Riggs Road, N.E.
Washington, D.C. 20011

*National Center for Health Statistics
Health Services and Mental Health
Administration
Public Health Service
Washington, D.C. 20201

Public Health Service
Rockville, Maryland 20852

Information Office News Clipping
Service
President's Committee on MR
Washington, D.C. 20201

Superentendent
Sunland Training Ctr
PO Box 852
Marianna, Florida 32446

*Goodwill-Suncoast, Inc.
Frank S. Greenberg, Dir
PO Box 10398
St. Petersburg, Florida 33733

*Florida ARC
Herbert F. Morgan, Ex Dir
220 East College Ave
Tallahassee, Florida 32301

*Benjamin B. Adams II
Division of Retardation
Rm 460 Larson Building
Tallahassee, Florida 32304

*Georgia ARC
Webb F. Spraetz, Ex Dir
Scott Hudgens Building, Suite 615
Atlanta, Georgia 30354

APPENDIX C (CONTINUED)

Georgia State Dept of Public Health
Division of Mental Retardation
47 Trinity Ave, S.W.
Atlanta, Georgia 30303

*Waimano Training School and Hospital
Pearl City, Hawaii 96782

Illinois Dept of Mental Health
State of Illinois Building
160 N LaSalle St, Rm 1500
Chicago, Illinois 60601

*Chicago-Read Mental Health Center
Marcia Schnedler, Public Information Officer
6500 Irving Park Rd
Chicago, Illinois 60634

Illinois ARC
Don Moss, Ex Dir
343 S Dearborn St, Suite 709
Chicago, Illinois 60604

Chicago State Hospital
H.C. Pomp, Supt.
6500 W Irving Park Rd
Chicago, Illinois 60634

*Ruth L. Turk
Interstate Clearing House on Mental Health
Council of State Governments
1313 East 60th St
Chicago, Illinois 60637

Dixon State School
2600 N Brinton Ave
Dixon, Illinois 61021

Opportunity House, Inc
C.R. Lindberg, Ex Dir
202 Lucas St
Sycamore, Illinois 60178

Holy Family Center
Kansas Elks Training Ctr
619 S Maize Rd
Wichita, Kansas 67209

Kentucky ARC
Bob R. Rundell, Ex Dir
101-A Bridge St
Frankfort, Kentucky 40601

Kentucky Dept of Mental Health
Division of MR
PO Box 678
Frankfort, Kentucky 40601

*Pineland Hospital and Training Center
Box C
Pownal, Maine 04069

State Department of Health
Division of Community Services for the MR
State Office Building
301 West Preston St
Baltimore, Maryland 21201

*Maryland ARC
William P. Cox, Ex Dir
1514 Reisterstown Rd
Pikesville, Maryland 21208

*Vocational Rehabilitation Unit
Michael F. Parker, Sup
Rosewood State Hospital
Owings Mills, Maryland 21117

*State Office of Mental Health
Margaret E. Pyne
15 Ashburton Place
Boston, Massachusetts 02108

Massachusetts ARC
Bernard Delman, Ex Dir
680 Main St, Suite 402
Waltham, Massachusetts 02154

*Department of Mental Health
Robert F. Marcus, Community Residence Program
Fernald State School

APPENDIX C (CONTINUED)

Box C
Waverley, Massachusetts 02178

Wrentham State School
Box 144
Wrentham, Massachusetts 02203

Department of Mental Health
Commission on Mental Retardation
Lansing, Michigan 48913

Michigan ARC
Harvey Zuckerberg, Ex Dir
510 Michigan National Tower
Lansing, Michigan 49080

Minnesota ARC
Gerald F. Walsh, Ex Dir
6519 Nicollet Ave
Minneapolis, Minnesota 55403

Fairview Hospital Rehabilitation Center
H.B. Dando, Coor
2312 S Sixth St
Minneapolis, Minnesota 55406

*Department of Public Welfare
Commission on Mental Retardation
Centennial Office Building
St. Paul, Minnesota 55101

Division of Mental Diseases
722 Jefferson St
Jefferson City, Missouri 65101

Missouri ARC
James R. Barnett, Ex Dir
1001-C Missouri Blvd
Jefferson City, Missouri 65101

Vocational Rehabilitation Unit
J.D. Schwaninger, Sup
Hastings State Hospital
Ingleside, Nebraska 68953

Nebraska ARC
John Foley, Ex Dir
1674 Van Dorn
Lincoln, Nebraska 68502

Department of Public Insti
State House Station
Box 94728
Lincoln, Nebraska 68509

* Nevada ARC
Dr. Theodore E. Johnson, Ex Dir
927 S Main St
Las Vegas, Nevada 89101

State Department of Health, Welfare, and Rehabilitation
Mental Hygiene Div
PO Box 2460
Reno, Nevada 89505

Bancroft Rehab Ctr
W.W. Burns, Sup
105 Pleasant St
Concord, New Hampshire 03301

*New Jersey ARC
John P. Scagnelli, Ex Dir
97 Bayard St
New Brunswick, New Jersey 08901

* Department of Institutions and Agencies
James M. Cronin, Sup
Bureau of Field Services
135 West Hanover St
PO Box 1237
Trenton, New Jersey, 08625

New Mexico ARC
Kermitt Stuve, Ex Dir
8200½ Menaul Blvd, N.E.
Albuquerque, New Mexico 87110

Health and Social Services
Commission on MR
PO Box 2348
Santa Fe, New Mexico 87501

APPENDIX C (CONTINUED)

*State Department of Mental Hygiene
David S. Baumstein
State School Community Affairs
Div of Mental Retardation
44 Holland Ave
Albany, New York 12208

Niagara Frontier Vocational Rehabilitation Center
100 Leroy Ave
Buffalo, New York 14214

*Newark State School
Frank R. Henne, MD, Dir
529 Church St
Newark, New York 14513

*New York State ARC
Joseph T. Weingold, Ex Dir
175 Fifth Ave
New York, New York 10010

*The Caswell Center
Vocational Rehab Facility
W.A. Dunne, Dir
PO Box 909
Kinston, North Carolina 28501

North Carolina ARC
Carey S. Pendley, Ex Dir
801 Lawyers Building
S Salisbury St
Raleigh, North Carolina 27601

North Carolina Dep of Mental Health
PO Box 9494
Raleigh, North Carolina 27601

Ohio Valley Goodwill Industries
W.Sharon Florer, Ex Dir
10600 Springfield Pike
Cincinnati, Ohio 45246

*Department of Mental Hygiene and Correction
Division of Mental Hygiene
Roger M. Grove, MD, Commissioner
12th Floor State Office Building
Columbus, Ohio 43215

*Ohio ARC
C.W. Perkins, Ex Dir
131 East State St, Suite 308
Columbus, Ohio 43215

The Columbus State Institute
1601 W Broad St
Columbus, Ohio 43223

Oregon ARC
David S. Kullowatz, Ex Dir
3085 River Road North
Salem, Oregon 97303

Oregon State Board of Control
Mental Health Division
2570 Center St, N.E.
Salem, Oregon 97310

Pennsylvania ARC
J.E. Van Dyke, Ex Dir
112 N Second St
Hall Building
Harrisburg, Pennsylvania 17101

*Department of Public Welfare
Office of Mental Health
Bruce Fessenden, Assistant to the Deputy Secretary for Mental Health and Mental Retardation
Harrisburg, Pennsylvania 17120

Allied Services Community Residential Ctr for MR
475 Morgan Hwy
Scranton, Pennsylvania 18519

*Texas ARC
David L. Williams, OJT Coor
833 W Houston
Austin, Texas 78756

APPENDIX C (CONTINUED)

*Department of Mental Health
and Mental Retardation
Box S, Capitol Station
Austin, Texas 78711

*Box 12668, Capitol Station

*Austin State School
B.R. Walker, Ph.D.,Sup
Box 1269
Austin, Texas 78767

*Vermont ARC
Emily C. Cota, Pres
PO Box 132
Charleston, Vermont 03603

*PO Box 132
Charlestown, N.H. 03603

*Department of Mental Health
Office of Mental Retardation
Helen J. Howe, Dir
Montpelier, Vermont 05602

Lynchburg Training School and
Hospital
B. Nagler, MD, Sup
PO Box 1098
Lynchburg, Virginia 24505

*Community Living Training
Unit, John Anderson, Dir
1510 Court
1510 N.E. 150th St
Seattle, Washington 98155

Washington ARC
David S. Alkins, Ex Dir
507 Security Building
Olympia, Washington 98501

Department of Institutions
Division for Handicapped
Children
PO Box 768
Olympia, Washington 98501

Wisconsin ARC
Merlen Kurth, Ex Dir
351 W Washington Ave
Madison, Wisconsin 53703

*Dane County Association for
Mental Health
406 N Pinckney St
Madison 3, Wisconsin

*De Paul Rehabilitation Hospital
Rev. A. Maroti, Ex Dir
4143 S. 13th St
Milwaukee, Wisconsin 53221

Gottsche Rehabilitation Center
Mrs. J. Hileman, Adm
Thermopolis, Wyoming 82443

APPENDIX D

Initial Cover Letter

FRESNO STATE COLLEGE
FRESNO, CALIFORNIA 93726

School of Education
Department of Advanced Studies

March 8, 1971

Dear Colleague:

We believe you have a unique service. In the United States, few group homes are helping retarded persons adjust to community living. In many ways you have a difficult job. Not much is known about the training that "works" in these community situations.

Will you please help us start finding answers by just answering 14 questions about your program?

No programs will be identified by name. However, if you would like to receive the results of the study, please give us your mailing address below.

May we ask you to please foreward the packet to us before next week?

Thank you for your help.

Yours very truly,

Gilbert P. Gia
Fellow in Mental Retardation
US Office of Education
Fresno State College

---Your address came to us through...

****

Please mail me a copy of the results in your study.

Name and Mailing Address:

APPENDIX E

Questionnaire

1. How many of your clients are mentally retarded (M.R)? _____

2. How many of your clients are

mentally ill _____ , physically involved _____ , other _____ .

3. Typically, how long do they stay with you?

Men: Months _____ Years _____ Women: _____ Months _____ Years _____

4. What are their approximate IQ's?

The High Group: IQ below 25 25 35 45 55 65 75 85 95
Middle Group : below 25 25 35 45 55 65 75 85 95
Low Group : below 25 25 35 45 55 65 75 85 95

5. In the last 3 years, how many male MR's have left

to live more independently? _____ . How many

Female MR's?– _____ .

6. How were these clients different from the others?

_____

_____

7. In the last 3 years, how many males left because

they could not benefit from the program? _____

How many female MR's? _____ .

8. What was the main reason they could not benefit from the program?_____

_____

9. Presently, how many male MR.'s live at your facility?

_____ . How many Female MR's?_____

10. How many of your clients get to school without help _____ ?To work?_____. Both?_____

11. Please check the places that are within a 20 minute walk of your facility: Public park _____ , Library _____ , Church _____, Public amusements (i.e. Movie) _____,

12 . How many of your MR clients go to these places on their own: Public Park _____ , Library _____ , Church _____ , Public Amusement _____.

13. How many MR's regularly was the dishes _____ , vacuum _____ , clean the bathroom _____ , make their own beds _____ , wash their own clothes _____ , help with yard work _____ .

14. How many MR clients pay part or all of their living expenses (i.e. rent)out of their own pockets?_____ (whether they are given the money or earn it)

Please seal the packet and mail it. We will mail you the results as soon as they are completed.

APPENDIX F

Second Cover Letter

FRESNO STATE COLLEGE
FRESNO, CALIFORNIA 93726

School of Education
Department of Advanced Studies

March 17, 1971

Dear Colleague:

You have probably not had time to fill out our request about your program.

Won't you please take a moment now to give us this brief information?

Sincerely,

Gilbert P. Gia

Gilbert P. Gia
Fellow in Mental Retardation
US Office of Education
Fresno State College

APPENDIX G

Addresses Mailed Questionnaires, and Addresses Referred
Too Late to Be Included in the Study

Three categories of addresses were included in Appendix G: the first was the group of residences that conformed to the internal delimitations of the study, and, therefore, were treated statistically. These addresses were signified by two asterisks. The second category represented residences that either did not return questionnaires, or were not mailed questionnaires because they were received late in the study. Addresses in this group were signified by one asterisk. The last category was composed of addresses of residences which did not conform to the internal delimitations of the study. These addresses appear without symbols.

APPENDIX G

Addresses Mailed Questionnaires, and Addresses Referred Too Late To Be Included in the Study

---

*Halfway House Program
Arizona Children's Colony
PO Box 1467
Coolidge, AZ 85228

*Pacific State Hospital
PO Box 100
Pomona, CA 91766

*Westmoreland House
Mervin Cooper, Ex Dir
939 S Westmoreland Ave
Los Angeles, CA 90006

*Development Center
DeWitt Hospital
Auburn, CA 95603

**Lorimer Lodge
228 St George
Toronto 180, Canada

**William D. Crosby, Chief
State Home and Training School
West Ridge, CO 80033

**Maynard Hesselbarth, Coor
Laradon Hall Training Ctr
5100 Lincoln
Denver, CO 80216

Residential and Training
Facility for Retarded
Julesburg, CO 80737

**Al Bickford, Dir
183 Crystal Park Rd
Manitou Springs, CO 80829

*Mansfield Social Adjustment Project
368 Asylum
Hartford, CT 06103

**(Two residences)
D.J. Cuvo
Social Services Department
Mansfield Training School
Mansfield Depot, CT 06251

**(Two residences)
Mrs. H.B. Wallat
Parents and Friends of MR Children
of Bridgeport, Inc.
4695 Main St
Bridgeport, CT 06606

**Sunrise House
126 W Adams St
Jacksonville, FL 32202

**Mrs. Mary Fenn Daniel, Coor
Wish House
220 East College Ave Rm 7
Tallahassee, FL 32301

*Blum's Rest Home
Route 1, Box 98-1
Altha, FL 32421

**Halfway House Program
Sunland Training Center
PO Box 852
Marianna, FL 32446

**BCARC
1694 Cedar St
Rockledge, FL 32955

APPENDIX G (CONTINUED)

**Bonnie Keller Group Home
822 12th Ct N.W.
Miami, FL 33125

*Mrs. Gladys Ayala Group Home
136 N.E. 50th St & Ter
Miami, FL 33137

**Palm Beach Girls Group
Living Home
Mrs. Dolores Norley, Sup
2509 N Dixie Hwy
West Palm Beach, FL 33407

**The Haven School
Louis R. Farrell, Dir
Route 4, Box 1082
Miami, FL 33156

**Palm Beach Habilitation Ctr
Robert H. Benedict, Ex Dir
4522 S Congress Ave
Lake Worth, FL 33460

*MacDonald Training Ctr
4424 Tampa Bay Blvd
Tampa, FL 33614

**PARC Villa
Bert Muller, Ex Dir
3100 75th St
St Petersburg, FL 33710

* Rehabilitation Residence
Edward Catchings, Dir
1313 Briarcliff Rd N.E.
Atlanta, GA 30306

**Paul Binns Residence
1801 Sylvan Rd S.W.
Atlanta, GA 30310

**John D. Helms Residence
1609 Woodland Ave S.E.
Atlanta, GA 30316

*Waimano Training School and
Hospital
Clarence Fukumae, Admin
Social Services and Placement
Pearl City, HI 96782

*(Three residences)
Department of Mental Health
Margaret E. Pyne
Commission on MR
190 Portland St
Boston, MA 02114

**Prospect House
269 Washington St
Somerville Branch
Boston, MA 02143

**Community Residence
65 Morse St
Watertown, MA 02172

*Rainbow House
106 Washington St
New Bedford, MA 02740

Wrentham State School
Box 144
Wrentham, MA 02293

*Belden Manor
2314 N Clark
Chicago, IL 60614

The Grasmere
4621 N Sheridan Rd
Chicago, IL 60640

*Approved Homes, Inc
909 W Wilson Ave
Chicago, IL 60640

*Director
4537 S Drexel Ave
Chicago, IL 60653

*Dixon State School
2600 Brinton Ave
Dixon, IL 61021

APPENDIX G (CONTINUED)

*Director
2316 Mt Royal Ter
Baltimore, MD 21217

**Rosewood State Hospital
Owings Mills, MD 21117

*Muskegon Avenue Center
c/o Dept of Mental Health
Lewis Cass Building
Lansing, MI 48913

Elaine Croom Residence
PO Box 38
Kinston, NC 28501

Sallie Wiggins Residence
405 W Washington St
Kinston, NC 28501

**Eastern Nebraska Community
Office of Retardation
116 S 42nd St
Omaha, NB 68131

**Bergen-Passaic ARC
Mort Melican, Dir
25 Broad
Palisades Park, NJ 07650

*Johnstone Training Center
32 S Clinton Ave
Trenton, NJ 08609

**Ruth K. Lee, Dir
Opportunity Village
927 S Main St
Las Vegas, NV 89101

**Mrs. Rita Kelk, Pers Officer
Letchworth Village
Theills, NY 10914

*Middletown State Hospital
Middletown, NY 10940

*Guild for Exceptional Children
310 67th St
Brooklyn, NY 11220

Oswald D. Heck School
44 Holland Ave
Albany, NY 12208

Wilton State School
Wilton, NY 12866

*Wassaic State School
Wassaic, NY 12592

Director, Halfway House Program
Mrs. Elizabeth Carroll
Personnel Officer
800 S Wilbur Ave
Syracuse, NY 13201

**Rome State School
Howard J. Waddell, Chief
Social Services
Box 550
Rome, NY 13441

*St. Lawrence State Hospital
Ogdensburg, NY 13669

**West Seneca State School
c/o Mrs. Phyllis Doyle
1200 East and West Rd
West Seneca, NY 14224

**(Three residences)
Newark State School
Frank R. Henne, MD, Dir
Newark, NY 14513

**Craig State School
Samuel M. Seltzer, Chief
Adult Habilitation Service
Sonyea, NY 14556

Sampson State School
Willard, NY 14588

APPENDIX G (CONTINUED)

**Sunny Haven Children's Home
Al Helmuth, Director
Plain City, OH 43064

Franklin County Council RC
129 East State St
Columbus, OH 43215

*Columbus State Institute
1601 W Broad St
Columbus, OH 43223

Cook Home for MR
Star Route 22, PO Box 95
Piedmont, OH 43983

**Homestead Farms
599 W Main St
Geneva, OH 44041

*Happy Acres
6381 N Ridge Rd
PO Box 265
North Madison, OH 44057

**Margie Home, Inc
Mr. T. Winfrey
6914 Woodland Ave
Cleveland, OH 44104

**Resident Home
Harvey Stein, Ex Dir
3042 W Fork Rd
Cincinnati, OH 45211

**Resident Homes
Mrs. Judy Hawkins, Admin
135 Tuxworth
Centerville, OH 45459

*Fairview Hospital and Training Center
2250 Strong Rd,S.E.
Salem, OR 97310

*Transitional Services
208 S Negley Ave
Pittsburgh, PA 15206

*Vocational Rehab Ctr
908 Penn Ave
Pittsburgh, PA 15222

*Eastern Orthodox Foundation
Box 432, 422 E Penn Run
Indiana, PA 15701

*Stairways
808 State St
Erie, PA 16501

*Allied Services Center
475 Morgan Hwy
Scranton, PA 18519

Tricounty Fountain Center
140 S Lansdowne Ave
Lansdowne, PA 19050

*Elwyn Institute
111 Elwyn Rd
Elwyn, PA 19063

Horizon House
1823 Pine St
Philadelphia, PA 19103

Rebecca Gratz Club
532 Spruce St
Philadelphia, PA 19106

**Marbridge House of Dallas
5110 Gaston
Dallas, TX 75214

*Boyd House
PO Box 5546
Longview, TX 75601

**Bethany House, Inc
PO Box 303
Hurst, TX 76053

*Vel'mont Halfway House
1640 Collins
Wichita Falls, TX 76301

APPENDIX G (CONTINUED)

Edwina Manor
2525 Austin
Waco, TX 76610

**Centex Edwina Monor
2525 Austine Ave
Waco, TX 76710

**Marbridge House of
Houston
5219 La Branch
Houston, TX 77004

*Home Program
2514 Driscoll St
PO Box 13403
Houston, TX 77019

**Richmond House
2414 Morse
Houston, TX 77019

**Harris County Center
for the Retarded
2514 Driscoll St
Houston, TX 77019

Magnificat House
5151 S Park Blvd
Houston, TX 77033

**Marbridge Community Living
Center
120 Pecore
Houston, TX 77009

*Land Manor
1900 Franklin St
Beaumont, TX 77701

**Fair Way House
1094 Mc Faddin St
Beaumont, TX 77701

**Mary Lee Halfway House
702 W Russell
San Antonio, TX 78212

*Goldsmith House
215 W Laurel
San Antonio, TX 78212

**Marbridge House of San Antonio
1718 San Pedro
San Antonio, TX 78212

*Pryor House
2321 N Main Ave
San Antonio, TX 78212

*Courtland House
201 E Courtland PL
San Antonio, TX 78212

**Chaparral House
821 Oak Park
Corpus Cristi, TX 78408

**Home Program
400 W Live Oak
Austin, TX 78704

**Marbridge House of Austin
711 W 21st St
Austin, TX 78705

*Austin State School
2203 W 35th
Austin, TX 78767

*Friendship House
1009 Madison
Amarillo, TX 79101

Park Place, Inc
1505 E Highway 80
Midland, TX 79701

Underwood Hall
900 NW 24th St
Amarillo, TX 79107

**Lubbock Halfway House
W. Dickson, Dir
1220 10th St
Lubbock, TX 79401

APPENDIX G (CONTINUED)

**Marbridge House
1217 N 19th St
Abilene, TX 79601

Big Spring Halfway House
901 W 3rd St
Big Spring, TX 79720

**Prude Ranch
Fort Davis, TX 79734

Marbridge House of Odessa
316 N Lincoln
Odessa, TX 79760

Clover House
407 W Second
Odessa, TX 79760

Rev Kenneth M. Lindsay
Bethesda Lutheran Home
700 Hoffman Dr
Watertown, WI 53094

**Social Adjustment Center
Mrs. Robert L. Hall, Dir
2501 Fish Hatchery Rd
Madison, WI 53713

**Home Living Center
Mr. Robert Allen, Dir
1676 Christiana
Green Bay, WI 54303

*Fircrest Halfway House
1510 N.E. 150th St
Seattle, WA 98155

APPENDIX H

Meanings Assigned to Columns on the Data Transmittal Form

APPENDIX H

Meanings Assigned to Columns on the Data Transmittal Form

Column Number(s)	Meaning
1, 2	Residence identification number
3	Biserial: 1=New residence, 2=More than 12 months old
4	Biserial: 1=California-based, 2=Outside California
5,6,7	Ratio of mentally ill to mentally retarded residents
8, 9	Length of stay in months
10, 11	Estimated IQ, a mean of questionnaire item 4
12, 13	Number of male retardates who left as successful in the last three years
14, 15	Number of female retardates who left as successful in the last three years
16, 17	Number of males retardates who left as unsuccessful in the last three years
18, 19	Number of female retardates who left as unsuccessful in the last three years
20, 21	Number of male residents
22, 23	Number of female residents
24, 25	Percentage of clients who go to school without help
26, 27	Percentage of clients who go to work without help
28, 29	Percentage that both go to school and work
30	Biserial: Public facilities available, 1=Yes, 2=No
31, 32	Percentage who use public facilities on their own
33, 34	Percentage who are involved in maintenance of home
35, 36	Percentage who make their own beds
37, 38	Percentage who wash their own clothes
39, 40	Percentage who pay a part or all of their rent out of their own pocket whether they are given the money or earn it.

APPENDIX I

Data Transmittal Forms

FRESNO STATE COLLEGE
COMPUTER CENTER
Fresno, California

DATA TRANSMITTAL FO

5	10	15	20	25	30	35	40	4
0 1 2 1 0	0 0 6 0 2	5 0 0 0 0	0 2 0 0 0	6 0 0 0 0	0 0 0 0 2	0 0 2 1 9	9 0 0 1 7	
0 2 2 1 0	2 5 6 0 6	0 0 0 0 0	0 0 0 0 0	0 4 0 0 0	0 0 0 0 1	9 9 9 9 9	9 0 0 0 0	
0 3 2 1 0	0 0 6 0 7	0 0 0 0 0	0 0 0 0 0	6 0 0 0 0	0 0 0 0 2	0 0 9 9 9	9 0 0 0 0	
0 4 2 1 0	0 0 6 0 5	5 0 0 0 0	0 0 0 0 0	5 0 0 6 0	0 0 0 0 1	0 0 5 0 6	0 6 0 9 9	
0 5 2 1 0	0 6 4 8 5	5 0 1 0 0	0 4 0 0 1	4 0 4 0 6	0 6 0 6 1	0 6 0 8 7	2 0 0 0 0	
0 6 2 1 0	0 0 6 0 5	0 0 1 0 0	0 1 0 0 0	6 0 6 0 0	0 0 0 0 1	7 5 9 9 9	9 0 0 0 0	
0 7 2 1 0	0 0 0 0 5	5 0 0 0 1	0 0 0 1 0	0 0 6 0 6	0 0 0 0 1	9 9 9 9 9	9 0 0 1 5	
0 8 2 1 1	0 0 6 0 8	0 0 1 0 0	0 0 0 0 0	6 0 0 0 0	0 0 0 0 2	0 0 0 0 5	0 0 0 0 0	
0 9 2 1 0	0 0 4 8 0	0 0 0 0 2	0 0 0 0 0	0 0 6 0 0	0 0 0 0 1	0 0 9 9 9	9 9 9 0 0	
1 0 2 1 0	0 0 2 4 2	5 0 0 0 1	0 0 0 0 0	2 0 0 5 0	5 0 0 0 1	9 9 9 9 9	9 0 0 5 0	
1 1 2 1 0	0 0 4 8 4	5 0 0 0 1	0 0 0 1 0	0 0 1 0 0	0 0 0 0 1	9 9 7 5 9	9 0 0 0 0	
1 2 2 1 0	0 0 6 0 2	5 0 0 0 0	0 0 0 0 0	1 0 0 0 0	0 0 0 0 1	0 0 0 0 0	0 0 0 0 0	
1 3 1 2 0	0 0 0 0 4	5 0 0 0 0	0 3 0 0 1	4 0 0 0 0	0 0 0 0 2	0 0 4 7 9	9 0 0 0 0	
1 4 1 2 0	0 0 2 4 6	5 0 0 0 0	0 0 0 1 1	0 0 5 0 0	9 9 0 0 1	7 5 6 9 9	9 5 0 0 0	
1 5 1 1 0	1 7 1 2 5	0 0 0 0 0	0 0 0 0 1	5 0 2 0 0	2 1 0 0 1	8 2 4 6 8	8 2 8 4 1	
1 6 1 2 0	2 0 0 0 6	5 0 0 0 0	0 0 0 0 0	0 0 5 0 0	0 5 0 0 1	7 0 9 9 9	9 9 9 0 0	
1 7 1 2 0	0 0 0 0 7	0 0 0 0 0	0 0 0 0 1	0 1 0 0 0	0 0 0 0 2	0 0 8 6 9	9 9 9 0 0	
1 8 1 2 0	0 0 0 0 6	5 0 3 0 0	0 0 0 0 1	0 0 4 0 0	0 0 0 0 1	3 8 9 9 9	9 0 0 1 0	
1 9 1 2 0	0 0 1 5 6	0 1 5 0 0	0 2 0 0 1	2 0 8 0 0	2 5 2 5 1	6 4 9 9 9	9 9 9 4 0	
2 0 1 2 0	0 0 1 0 6	5 5 0 0 5	1 5 0 4 2	5 1 5 9 9	9 9 9 9 1	9 1 9 9 9	9 9 9 9 9	
2 1 1 2 0	0 0 0 6 5	5 0 7 0 7	0 1 0 0 0	7 0 7 0 0	1 4 0 0 1	6 5 9 9 9	9 9 9 9 9	
2 2 1 2 0	0 0 0 9 6	5 0 0 0 0	0 0 0 0 2	3 0 0 0 0	2 3 0 0 1	9 9 9 9 9	9 9 9 0 0	
2 3 1 2 0	0 0 0 6 5	0 0 2 0 0	0 2 0 0 1	6 0 0 9 9	3 7 9 9 1	8 5 9 9 9	9 5 0 2 5	
2 4 1 2 0	0 0 0 4 7	5 0 7 0 0	0 3 0 0 0	7 0 0 0 0	0 0 0 0 1	9 9 9 9 9	9 9 9 4 3	
2 5 1 2 0	0 0 0 6 6	5 1 2 0 0	0 1 0 0 1	8 0 0 0 0	1 8 0 0 1	7 4 1 9 9	9 9 9 9 9	
2 6 1 2 0	0 0 0 9 6	5 0 0 0 0	0 0 0 0 0	8 0 4 9 9	9 9 9 9 1	9 9 9 9 9	9 9 9 9 9	
2 7 1 2 0	3 6 0 9 7	5 2 5 5 0	5 0 1 2 0	6 5 0 0 7	5 4 0 0 1	2 7 9 0 9	0 9 0 5 4	

1,2,3,4,5|6,7,8,9,10|11,12,13,14,15|16,17,18,19,20|21,22,23,24,25|26,27,28,29,30|31,32,33,34,35|36,37,38,39,40|41,42,43,44,

FSCCC Form #245 11/25/70

FRESNO STATE CO
COMPUTER CENT
Fresno, Califo

DATA TRANSMITTA

5	10	15	20	25	30	35	40
2822000204	1000000001	5153000002	5007500000				
2922000187	5000000000	0089999991	7599999999				
3022000077	0000000001	1000000001	8241999999				
3122004604	5010010004	8001727021	1912250031				
32220210075	0100000008	0600990019	9999999999				
3322000486	5040000004	3000099001	9999999999				
3422000605	5000200030	0150000017	7999999000				
3522025064	5010000000	3020301001	2493867048				
3622020127	5000100020	0050099001	9999999980				
3722000245	8100002002	6000099001	9999999999				
3822006155	0042306101	9353737371	4340995033				
3922000307	0140015002	8000000001	9999999999				
4022000366	5002500120	0410099001	9999999999				
4122000126	5002000060	0200000001	9999999999				
4222000247	0002900500	0220099001	9999999999				
4322000067	0211003021	6000000001	9980990000				
44222300975	1400010005	0099000027	5999999000				
4522000365	1410060406	0499000012	5250000000				
4622000156	5002000040	2029999991	5099999925				
4722000106	5120000000	2009999991	9999999999				
48221000975	2630140300	4009999991	6999999999				
4922000125	5160004001	8000099002	0099999950				
5022014046	0000000000	0700000700	1272799009				
5122000606	0201007150	8209999991	9999999999				
5222000125	5000003000	7007228001	0054992929				
5322007186	5201516062	0260009000	1509999950				
5422000605	5030006003	5000000001	5050990000				

1,2,3,4,5 | 6,7,8,9,10 | 11,12,13,14,15 | 16,17,18,19,20 | 21,22,23,24,25 | 26,27,28,29,30 | 31,32,33,34,35 | 36,37,38,39,40 | 41,42

FSCCC Form #245 11/25/70

FRESNO STATE CO
COMPUTER CENT
Fresno, Califo

DATA TRANSMITTA

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57220004865000000028000071001358197075
581200      0606
5922100603503000200330000090010128009100
6022000245500040004003100990018299999958
6121006062000100020619000000200274089000
6221   60      0001
6312000   600101010014140099001999999999999
6421000   750000001003419143113149951803
6522018066201080100181000000020099999900
6622000206505000100120000099001729999999999
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6822000083310120302151299000020007050500
6922008   5502020000180633990013390999999
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1,2,3,4,5|6,7,8,9,10|11,12,13,14,15|16,17,18,19,20|21,22,23,24,25|26,27,28,29,30|31,32,33,34,35|36,37,38,39,40|41,42,

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